2004 Benefits Guide

Colorado Department of Personnel & Administration

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This guide and the accompanying materials are provided as an overview of the 2004 group benefit plans offered to State of Colorado employees and their eligible dependents. The group benefit plans include medical, dental, life insurance, Health and/or Dependent Day Care Flexible Spending Accounts, Short-Term Disability, Long-Term Disability, and Tax Deferred Savings plans. These enrollment materials do not constitute a binding contract with employees and/or dependents and the State of Colorado. Every effort was made to ensure the accuracy of the information contained in these materials.

The terms and conditions of the state's group benefit plans are controlled by the group master contracts, plan documents, the State Benefit Plans section of the State Personnel Director's Administrative Procedures, and Employee Benefits Written Directives. In the event of a conflict with federal regulations and state statutes, the governing laws will prevail. A copy of the administrative procedures is maintained and available for review through your agency payroll or personnel administrator.

The plans offered by the state are intended and expected to continue, however, the state reserves the right to discontinue or revise these plans at any time. In addition to this guide, other methods of communication such as memos, meetings, newspaper articles, direct mail and electronic media, are used to help keep you informed. For questions prior to enrolling in any of the state's group benefit plans, contact each carrier directly at the phone number listed in the 2004 Benefit Premium card or consult with your agency payroll or personnel administrator. Once you've enrolled, direct your questions to the appropriate carrier(s).

Review this guide carefully and make benefit decisions to meet your and your family's particular needs.

Fraud

It is unlawful for any employee, employee's dependent(s) or other individual(s) to knowingly and intentionally provide false, incomplete, or misleading facts or information on any benefits enrollment form, affidavit, or other document for the purpose of defrauding or attempting to defraud the State of Colorado with regards to the application or claim for group benefits. Penalties may include imprisonment, fines, denial for or termination of enrollment in any or all of the state's group benefit plans, civil damages, or as provided in regulations, statutes, and written directives.

Warning: **If you are insured under a separate group medical insurance policy, you may be subject to coordination of benefits as explained in this booklet.**

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The State of Colorado offers a variety of healthcare plan options designed to meet individual healthcare and financial requirements. The State of Colorado offers the statewide and regional options listed below to eligible employees.

Rocky Mountain HMO is no longer offered for 2004. Employees who had Rocky Mountain HMO and want to continue medical coverage for 2004 must use the On-line Open Enrollment System to enroll in another state-offered plan.

Carefully review and compare rates, plan changes, and health plan descriptions for 2004 when making your decisions.

2004 Statewide Plans:
Anthem Liberty EPO
Anthem Centennial PPO

2004 Regional Plans:
Kaiser Permanente HMO
San Luis Valley HMO
PacifiCare HMO

Plans	Carrier Premium Rates	State Contribution	Subtotal Employee Cost	State Administration Fee	Total Employee Cost
Anthem Liberty EPO					
Employee	$ 324.48	$ 156.06	$ 168.42	$ 3.30	$ 171.72
Employee +1	$ 648.94	$ 232.52	$ 416.42	$ 3.30	$ 419.72
Family	$ 908.50	$ 326.46	$ 582.04	$ 3.30	$ 585.34
Anthem Centennial PPO					
Employee	$ 220.50	$ 156.06	$ 64.44	$ 3.30	$ 67.74
Employee +1	$ 441.02	$ 232.52	$ 208.50	$ 3.30	$ 211.80
Family	$ 617.46	$ 326.46	$ 291.00	$ 3.30	$ 294.30
Kaiser HMO					
Employee	$ 246.40	$ 156.06	$ 90.34	$ 3.30	$ 93.64
Employee +1	$ 492.78	$ 232.52	$ 260.26	$ 3.30	$ 263.56
Family	$ 689.90	$ 326.46	$ 363.44	$ 3.30	$ 366.74
San Luis Valley HMO					
Employee	$ 272.76	$ 156.06	$ 116.70	$ 3.30	$ 120.00
Employee +1	$ 545.50	$ 232.52	$ 312.98	$ 3.30	$ 316.28
Family	$ 764.02	$ 326.46	$ 437.56	$ 3.30	$ 440.86
PacifiCare HMO					
Employee	$ 393.70	$ 156.06	$ 237.64	$ 3.30	$ 240.94
Employee +1	$ 787.42	$ 232.52	$ 554.90	$ 3.30	$ 558.20
Family	$ 1,102.40	$ 326.46	$ 775.94	$ 3.30	$ 779.24

Anthem Liberty EPO
Routine Vision - Added Anthem Vision to plan. One routine exam every 12 months, $20 copay.

Anthem Centennial PPO
Routine Vision - No longer subject to deductible/coinsurance. Replaced with Anthem Vision - One routine exam every 12 months, $20 copay.

Kaiser Permanente HMO
Prescription drug benefit changed from a 60-day supply of prescription drugs to a 30-day supply. MRI, CAT, and PET scans will be provided at a co-payment of $100.00 for each type of outpatient procedure.

PacifiCare HMO
The maximum day limit for alcoholism from 21 days to 45 days.

San Luis Valley
San Luis Valley has introduced several changes in its co-payment structure for a number of benefits including prescription drugs, laboratory, x-ray, durable medical equipment and oxygen. The restructuring applies to SLVHMO's group business as a whole, not just the state plan. The revised structure will help mitigate adverse selection against the plan.

This summer, San Luis Valley HMO launched its Chronic Disease Management Program with an initial focus on diabetes. According to SLVHMO data, diabetes affects at least 3% of their members. In July, SLVHMO offered free A1c testing to all those in the target diabetes population who had not had the test within the previous six months. With ample scientific evidence that good glucose control among diabetics can dramatically reduce the incidence of heart disease, kidney disease, blindness and amputations, SLVHMO believes a strong program will improve the quality of life for those members suffering from diabetes.

Colorado Health Plan Description Form
Anthem Blue Cross and Blue Shield
Liberty (EPO)
Effective January 1, 2004

PART A: TYPE OF COVERAGE

1	**TYPE OF PLAN**	Preferred provider plan
2	**OUT-OF-NETWORK CARE COVERED?** [1]	Only for emergency care
3	**AREAS OF COLORADO WHERE PLAN IS AVAILABLE**	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

		IN-NETWORK (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4	**ANNUAL DEDUCTIBLE**	
a)	**Individual**	No deductibles
b)	**Family**	No deductibles
5	**OUT-OF-POCKET ANNUAL MAXIMUM** [2]	
a)	**Individual**	$2,000 + copayments
b)	**Family**	$6,000 aggregate + copayments
6	**LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE**	No Lifetime Maximum
7 a)	**COVERED PROVIDERS**	Anthem Blue Cross and Blue Shield PPO Provider Network. See provider
7 b)	**WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 7A. ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?**	Yes
8	**ROUTINE MEDICAL OFFICE VISITS**	100% after $50 per office visit copayment
9	**PREVENTIVE CARE**	
a)	**Children's Services**	100% after $50 per office visit copayment includes immunizations (up to age 13)
b)	**Adult's Services**	100% after $50 per office visit copayment for routine exam
10	**MATERNITY**	
a)	**Prenatal care**	100% after $50 per office visit copayment
b)	**Delivery & inpatient well baby care**	$400 copayment per day for the first five days, then 100% until discharge, per admission

11 PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions	
a) Inpatient care	Included in hospital copayment (see line 12)
b) Outpatient care	Tier 1 generic formulary $15, tier 2 brand formulary $40, tier 3 nonformulary $60, tier 4 self-administered injectable drugs 30%, per prescription up to a 34-day supply.
c) Prescription Mail Service	Tier 1 generic formulary $30, tier 2 brand formulary $100, tier 3 nonformulary $150, tier 4 self-administered injectable drugs 30%, per prescription up to a 90-day supply. For the tier 4 self-administered injectable prescription drugs, the 34-day supply maximum coinsurance per prescription is $250 and $500 per 90-day supply. Includes coverage for smoking cessation prescription legend drugs when enrolled in an Anthem Blue Cross and Blue Shield approved smoking cessation counseling program, up to $250 per member per calendar year, $500 per lifetime. If a provider prescribes a drug for which an FDA-approved Class A generic substitute is available, the benefit will be limited to the cost of the generic substitute. All medically necessary "dispense as written" and "no substitution" prescriptions do not allow a generic substitution and require prior authorization from Anthem Blue Cross and Blue Shield. If a brand name drug is used when a generic equivalent is available, you pay the brand formulary copayment or nonformulary copayment plus the retail cost difference be ween the brand name drug and generic substitution. For drugs on our approved list, contact Customer Service at 1-800-843-5621 or 303-831-2384. Prescription drugs will be covered only when received from a participating pharmacy.
12 INPATIENT HOSPITAL	$400 copayment per day for first five days then 100% until discharge, per admission
13 OUTPATIENT/AMBULATORY SURGERY	100% after $200 per surgery copayment
14 LABORATORY AND X-RAY	
a) Individual	Included with inpatient hospital copayment (see line 12)
b) Family	$50 per office visit copayment or 20% coinsurance if billed by separate provider of care
15 EMERGENCY CARE [3]	100% after $100 per emergency room visit copayment (waived if admitted to hospital) in or out-of-network
16 AMBULANCE	
a) Ground	100% after $200 per trip copayment (maximum benefit of $350 per trip)
b) Air	100% after $500 per trip copayment (maximum benefit of $2,500 per trip)
17 URGENT, NON-ROUTINE, AFTER HOURS CARE	
a) Inpatient care	$400 copayment per day for first five days then 100% until discharge, per admission
b) Outpatient care	100% after $75 per office visit copayment
18 BIOLOGICALLY-BASED MENTAL ILLNESS [4] **CARE**	Coverage is no less extensive than the coverage provided for any other physical illness.
19 0THER MENTAL HEALTH CARE	
a) Inpatient care	50% coinsurance per admission (limited to 45 full or 90 partial days per calendar year combined with Alcohol Abuse benefits (line 20)
b) Outpatient care	50% coinsurance per visit (limited to 30 visits with no less than $1,000 in benefits per calendar year)

20 ALCOHOL & SUBSTANCE ABUSE	
a) Inpatient care	Alcohol abuse: 50% coinsurance per admission (limited to 45 days per year or 90 partial days per calendar year combined with Mental Health benefits (line 19) Substance abuse: 50% coinsurance per admission (limited to 30 days per calendar year or 60 days per lifetime)
b) Outpatient care	50% coinsurance per visit (limited to 20 visits with no less than $500 in benefits per calendar year for alcohol abuse; limited to 15 visits per calendar year for substance abuse)
21 PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	
a) Inpatient care	Included with inpatient hospital copayment (see line 1
b) Outpatient care	100% after $50 per office visit copayment (limited to 20 visits per calendar; for children limited to 20 therapy visits per calendar year each for physical, occupational and speech therapy up to age 5)
22 DURABLE MEDICAL EQUIPMENT	
a) Inpatient care	Included with inpatient hospital copayment (see line 12)
b) Outpatient care	20% coinsurance (limited to a maximum payment of $3,000 per calendar year, combined with oxygen (line 23), except for prosthetic devices which are not subject to the maximum payment but do reduce the maximum payment of $3,000
23 OXYGEN	
a) Inpatient care	Included with inpatient hospital copayment (see line 12)
b) Outpatient care	20% coinsurance (limited to a maximum payment of $3,000 per calendar year, combined with durable medical equipment (line 22))
24 ORGAN TRANSPLANTS	$400 copayment per day for first five days then 100% until discharge, per admission
25 HOME HEALTH CARE	100% after $50 per visit copayment (limited to 60 visits per calendar year)
26 HOSPICE CARE	
a) Inpatient	20% coinsurance (limited to 30 days per calendar year)
b) Outpatient	20% coinsurance (limited to 91 days per calendar year)
27 SKILLED NURSING FACILITY CARE	Not Covered
28 DENTAL CARE	No dental benefits are available under this medical plan. However, the State of Colorado offers a separate dental plan for eligible employees and dependents. See enrollment materials.
29 VISION CARE	Vision benefits included in this plan can be found on the separate Anthem Vision Summary Description.
30 CHIROPRACTIC CARE	100% after $50 per visit copayment (limited to annual payment of $300)
31 SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	BlueCares for You disease management programs that include management for CAD, CHF, ESRD, maternity, asthma, diabetes, and a 24-hour nurse healthline. When a member desires another professional opinion, they may obtain a second surgical opinion subject to plan provisions.

PART C: LIMITATIONS AND EXCLUSIONS		
32	**PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED** [5]	Not applicable. Plan does not impose limitation periods for preexisting conditions.
33	**EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?**	No
34	**HOW DOES THE POLICY DEFINE A "PREEXISTING CONDITION"?**	Not applicable. Plan does not exclude coverage for pre-existing conditions.
35	**WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?**	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan, sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.
PART D: USING THE PLAN		
36	**Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?**	No
37	**Is prior authorization required for surgical procedures and hospital care (except in an emergency)?**	Yes
38	**If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?**	No
39	**What is the main customer service number?**	303-831-2384 or 1-800-843-5621
40	**Whom do I write/call if I have a complaint or want to file a grievance** [6]	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-2384 or 1-800-843-5621
41	**Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?**	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42	**To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.**	Policy form # 98467 Large Group

PART E: COST

43	**What is the cost of this plan?**	**Employee Portion**	**StateContribution**	**FullPremium**
	Employee only	$171.72	$156.06	$324.48
	Employee + 1 dep.	$419.72	$232.52	$648.94
	Employee + 2 or more dep.	$585.34	$326.46	$908.50

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH

Any person interested in applying for coverage, or who is covered by or who purchased coverage under this plan, may request answers to the

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit?

Endnotes:

1. "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2. "Out of Pocket Maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.

3. "Emergency Care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or-limb threatening emergency existed

4. "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressivedisorder, specific obsessive-compulsive disorder, and panic disorder.

5. Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

6. Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Colorado Health Plan Description Form
Anthem Blue Cross and Blue Shield
Centennial (PPO)
Effective January 1, 2004

PART A: TYPE OF COVERAGE

1	**TYPE OF PLAN**	Preferred provider plan
2	**OUT-OF-NETWORK CARE COVERED?** [1]	Yes, but patient pays more for out-of-network care.
3	**AREAS OF COLORADO WHERE PLAN IS AVAILABLE**	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

		IN-NETWORK	OUT-OF-NETWORK
4	**ANNUAL DEDUCTIBLE**		
a)	**Individual**	$2,000	$4,000
b)	**Family**	$4,000 for all family members	$8,000 for all family members
5	**OUT-OF-POCKET ANNUAL MAXIMUM** [2]	$5,000 + Deductible individual or $10,000 + Deductible family The in-network out-of-pocket maximum is not applied towards the out-ofnetwork out-of-pocket maximum	$10,000 + Deductible individual $20,000 + Deductible family The out-of-network out-of-pocket maximum is not applied towards the in-network out-of-pocket maximum
6	**LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE**	No lifetime maximum	No lifetime maximum
7 a)	**COVERED PROVIDERS**	PPO Provider Network. See provider directory for complete list.	All providers licensed or certified to provide covered benefits.
7 b)	**WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 7A. ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?**	Yes	Not applicable
8	**ROUTINE MEDICAL OFFICE VISITS**	80% after deductible	60% after deductible
9	**PREVENTIVE CARE**		
a)	**Children's Services**	80% not subject to deductible (up to age 13)	60% not subject to deductible (up to age 13)
b)	**Adult's Services**	80% after deductible	80% after deductible
10	**MATERNITY**		
a)	**Prenatal care**	80% after deductible	60% after deductible
b)	**Delivery & inpatient well baby care**	80% after deductible	60% after deductible

11	**PRESCRIPTION DRUGS** Level of coverage and restrictions on prescriptions		
	a) Inpatient care	80% after deductible	60% after deductible
	b) Outpatient care	Tier 1 generic formulary $15, tier 2 brand formulary $40, tier 3 nonformulary $60, tier 4 self-administered injectable drugs 30%, per prescription up to a 34-day supply.	Not Covered
	c) Prescription Mail Service	Tier 1 generic formulary $30, tier 2 brand formulary $100, tier 3 nonformulary $150, tier 4 self-administered injectable drugs 30%, per prescription up to a 90-day supply. For the tier 4 self-administered injectable prescription drugs, the 34-day supply maximum coinsurance per prescription is $250 and $500 per 90-day supply. Includes coverage for smoking cessation prescription legend drugs when enrolled in an Anthem Blue Cross and Blue Shield approved smoking cessation counseling program, up to $250 per member per calendar year, $500 per lifetime. If a provider prescribes a drug for which an FDA-approved Class A generic substitute is available, the benefit will be limited to the cost of the generic substitute. All medically necessary "dispense as written" and "no substitution" prescriptions do not allow a generic substitution and require prior authorization from Anthem Blue Cross and Blue Shield. If a brand name drug is used when a generic equivalent is available, you pay the brand formulary copayment or nonformulary copayment plus the retail cost difference between the brand name drug and generic substitution. For drugs on our approved list, contact Customer Service at 1-800-843-5621 or 303-831-2384. Prescription drugs will be covered only when received from a participating pharmacy.	Not Covered
12	**INPATIENT HOSPITAL**	80% after deductible	60% after deductible
13	**OUTPATIENT/AMBULATORY SURGERY**	80% after deductible	60% after deductible
14	**LABORATORY AND X-RAY**	80% after deductible	60% after deductible
15	**EMERGENCY CARE** [3]	80% after deductible	60% after deductible
16	**AMBULANCE**	80% after deductible (limited to $350 per trip for ground ambulance and $2,500 per trip for air ambulance)	60% after deductible (limited $350 per trip for ground ambulance and $2,500 per trip for air ambulance)

17	**URGENT, NON-ROUTINE, AFTER HOURS CARE**	80% after deductible	60% after deductible
18	**BIOLOGICALLY-BASED MENTAL ILLNESS [4] CARE**	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive the coverage provided for any other physical illness.
19	**0THER MENTAL HEALTH CARE**		
	a) Inpatient care	80% after deductible (limited to 45 full or 90 partial days per member per calendar year combined with out-of-network)	60% after deductible (limited to 45 full or 90 partial days per member per calendar year combined with in-network)
	b) Outpatient care	80% after deductible (limited to 30 visits per member per calendar year combined with out-of-network and line 20 outpatient alcohol and substance abuse, with no less than $1,000 in benefits for mental health care)	60% after deductible (limited to 30 visits per member per calendar year combined with in-network and line 20 outpatient alcohol and substance abuse, with no less than $1,000 in benefits for mental health care)
20	**ALCOHOL & SUBSTANCE ABUSE**		
	a) Inpatient care	80% after deductible limited to medically necessary care	60% after deductible limited to medically necessary care
	b) Outpatient care	80% after deductible (limited to 30 visits per member per calendar year combined with out-of-network and line 19 outpatient mental health care, with no less than $500 in benefits for alcohol abuse and no less than $250 in benefits for substance abuse)	60% after deductible (limited to 30 visits per member per calendar year combined with in-network and line 19 outpatient mental health care, with no less than $500 in benefits for alcohol abuse and no less than $250 in benefits for substance abuse)
21	**PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY**	80% after deductible	60% after deductible
22	**DURABLE MEDICAL EQUIPMENT**	80% after deductible	60% after deductible
23	**OXYGEN**	80% after deductible	60% after deductible
24	**ORGAN TRANSPLANTS**	80% after deductible	60% after deductible
25	**HOME HEALTH CARE**	80% after deductible (up to 60 visits per calendar year combined with out-ofnetwork benefits)	60% after deductible (up to 60 visits per calendar year combined with in-network benefits)
26	**HOSPICE CARE**		
	a) Inpatient	80% after deductible	60% after deductible
	b) Outpatient	80% after deductible	60% after deductible
27	**SKILLED NURSING FACILITY CARE**	Not Covered	Not Covered
28	**DENTAL CARE**	No dental benefits are available under this medical plan. However, the State of Colorado offers a separate dental plan for eligible employees and dependents. See enrollment materials.	
29	**VISION CARE**	Vision benefits included in this plan can be found on the separate Anthem Vision Summary Description.	
30	**CHIROPRACTIC CARE**	80% after deductible (limited to a maximum payment of $750 per calendar year combined with out-of-network)	60% after deductible (limited to a maximum payment of $750 per calendar year combined with innetwork)

31	**SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)**	BlueCares for You disease management programs that include management for CAD, CHF, ESRD, maternity, asthma, diabetes, and a 24-hour nurse healthline. Hearing aids, exam and fitting not subject to deductible or coinsurance (limited to maximum payment of $500 every three years combined with out-of-network) Infertility treatment 80%, subject to deductible (limited to a maximum payment of $2,500 per calendar year combined with out-of-network) When a member desires another professional opinion, they may obtain a second surgical opinion subject to plan provisions.	BlueCares for You disease management programs that include management for CAD, CHF, ESRD, maternity, asthma, diabetes, and 24-hour nurse a healthline. Hearing aids, exam and fitting not subject to deductible or coinsurance (limited to maximum payment of $500 every three years combined with in-network) Infertility treatment 60%, subject to deductible (limited to a maximum payment of $2,500 per calendar year combined with innetwork) When a member desires another professional opinion, they may obtain a second surgical opinion subject to plan provisions.
PART C: LIMITATIONS AND EXCLUSIONS			
32	**PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED** [5]	Not applicable. Plan does not impose limitation periods for preexisting conditions.	
33	**EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?**	No	
34	**HOW DOES THE POLICY DEFINE A "PREEXISTING CONDITION"?**	Not applicable. Plan does not exclude coverage for pre-existing conditions.	
35	**WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?**	Exclusions vary by policy; a list of exclusions is available immediately upon request from your carrier or plan sponsor (e.g. employer). Review them to see if a service or treatment you may need is excluded from the policy.	
PART D: USING THE PLAN			
36	**Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?**	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
37	**Is prior authorization required for surgical procedures and hospital care (except in an emergency)?**	Yes	Yes
38	**If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?**	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
39	**What is the main customer service number?**	303-831-2384 or 1-800-843-5621	
40	**Whom do I write/call if I have a complaint or want to file a grievance** [6]	Anthem BCBS Complaints and Appeals	
41	**Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?**	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202	
42	**To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.**	Policy form # 96744 Large group	
PART E: COST			
43	**What is the cost of this plan?**	**Employee Portion**	**StateContribution** / **FullPremium**
	Employee only	$67.74	$156.06 / $220.50
	Employee + 1 dep.	$211.80	$232.52 / $441.02
	Employee + 2 or more dep.	$294.30	$326.46 / $617.46

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH

Any person interested in applying for coverage, or who is covered by or who purchased coverage under this plan, may request answers to the

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit?

Endnotes:

1. "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2. "Out of Pocket Maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.

3. "Emergency Care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or-limb threatening emergency existed.

4. "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressivedisorder, specific obsessive-compulsive disorder, and panic disorder.

5. Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

6. Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

DPA

Colorado Health Plan Description Form
Kaiser Permanente
HMO
Effective January 1, 2004

KAISER PERMANENTE

PART A: TYPE OF COVERAGE

1	**TYPE OF PLAN**	Health Maintenance Organization (HMO)
2	**OUT-OF-NETWORK CARE COVERED?** [1]	Only for Emergency Care
3	**AREAS OF COLORADO WHERE PLAN IS AVAILABLE**	Denver/Boulder: portions of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld counties within the following zip codes: 80001-7, 80010-22, 80024-28, 80030, 80031, 80033-38, 80040-42, 80044-47, 80102, 80104, 80107-13, 80116-17, 80120-31, 80134-35, 80137-38, 80150-51, 80154-55, 80160-63, 80201-12, 80214-39, 80241, 80243-44, 80246-52, 80254-56, 80259, 80260-66, 80270-71, 80273-75, 80279-81, 80290-95, 80299, 80301-10, 80314, 80321-23, 80328-80329, 80401-3, 80421-22, 80425, 80427, 80433, 80437, 80439, 80452-55, 80457, 80465-66, 80470-71, 80474, 80481, 80501-4, 80510, 80513-14, 80516, 80520, 80530, 80533-34, 80537-40, 80542-44, 80600-03, 80614, 80621, 80623, 80640, 80642-43, 80651. Colo. Spgs.: portions of Douglas, El Paso, Fremont, Park, Pueblo and Teller counties within the following zip codes: 80106, 80118, 80132-33, 80808-09, 80813-14, 80816-17, 80819-20, 80827, 80829, 80831-33, 80840-41, 80860, 80863-64, 80866, 80901, 80903-22, 80925-26, 80928-37, 80940-47, 80949-50, 80960, 80962, 80970, 80977, 80995, 80997, 81007-08, 81212, 81240.

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

		IN-NETWORK (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4	**ANNUAL DEDUCTIBLE**	
a)	**Individual**	No deductibles
b)	**Family**	No deductibles
5	**OUT-OF-POCKET ANNUAL MAXIMUM** [2]	
a)	**Individual**	$3,000/Individual
b)	**Family**	$6,000/Family
6	**LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE**	No Lifetime Maximum
7 a)	**COVERED PROVIDERS**	Colorado Permanente Medical Group, P.C. See Provider Directory for complete list
7 b)	**WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 7A. ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?**	Not applicable - this is not a network plan
8	**ROUTINE MEDICAL OFFICE VISITS**	$30 per primary care office visit copay $50 per specialist office visit copay
9	**PREVENTIVE CARE**	
a)	**Children's Services**	$15 per visit copay for PCP
b)	**Adult's Services**	$15 per visit copay for PCP
10	**MATERNITY**	
a)	**Prenatal care**	$15 per visit copay for PCP
b)	**Delivery & inpatient well baby care**	$1,000 copay per admission / Individual

11 PRESCRIPTION DRUGS Level of coverage and restrictions on	$15 generic/$40 brand up to a 30-day supply *for more details, please see attached addendum. for drugs on our approved list, please contact your Medical Office Pharmacist
12 INPATIENT HOSPITAL	$1,000 copay per admission/Individual
13 OUTPATIENT/AMBULATORY SURGERY	$150 per procedure copay
14 LABORATORY AND X-RAY	Diagnostic Lab and X-ray - No copay (100% covered) Therapeutic X-ray - $50 per visit copay MRI/CAT/PET - $100 per procedure copay
15 EMERGENCY CARE [3]	$100 per visit copay at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient. Payment of non-Plan emergency claims is limited to usual reasonable and customary charges.
16 AMBULANCE	20% up to a maximum of $500 per trip
17 URGENT, NON-ROUTINE, AFTER HOURS CARE	$100 per visit copay at a designated Kaiser Permanente emergency room $30 per visit copay at a Kaiser Permanente medical office during office hours. $50 per after hours visit copay at designated Kaiser Permanente medical offices
18 BIOLOGICALLY-BASED MENTAL ILLNESS [4] **CARE**	Coverage is no less extensive than the coverage provided for any other physical illness.
19 0THER MENTAL HEALTH CARE	
a) Inpatient care	50% copay per admission - up to 45 days each calendar year
b) Outpatient care	$30 copay each visit up to 20 visits each calendar year. Group visits will be charged at half the copay of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.
20 ALCOHOL & SUBSTANCE ABUSE	
a) Inpatient Medical Detoxification	$1,000 copay per admission/Individual
b) Inpatient Residential Rehabilitation	50% coinsurance up to 45 days each
c) Outpatient Chemical Dependency	$30 copay per visit up to 20 visits each calendar year. Group visits will be charged at half the copay of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.
21 PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	
a) Inpatient care	$1,000 copay per admission/Individual for conditions subject to significant improvement within two months
b) Outpatient care	$30 per visit copay for up to two months per condition, or up to 20 visits per condition if 20 or more visits are not received within two months, for conditions subject to significant improvement within two months *Therapy for congenital defects and birth abnormalities is covered for children up to age five for both acute and chronic conditions.
22 DURABLE MEDICAL EQUIPMENT	No copay up to $2,000 each calendar year within the Service Area. Prosthetic arms and legs covered at no copay (100% covered) with no annual maximum. See policy for types and circumstances of coverage
23 OXYGEN	20% copay
24 ORGAN TRANSPLANTS	
a) Major Organ Transplant	$1,000 copay per admission/Individual - no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea and liver, small bowel/small bowel and liver
25 HOME HEALTH CARE	No copay (100% covered) for prescribed medically necessary home health services. Not covered outside the Service Area
26 HOSPICE CARE	No copay (100% covered) for home-based hospice care. Not covered outside the Service Area.

27	**SKILLED NURSING FACILITY CARE**	No copay (100% covered) for up to 100 days for prescribed skilled nursing facility services at approved skilled nursing facilities. Not covered outside the Service Area
28	**DENTAL CARE**	No coverage provided
29	**VISION CARE**	$30 per primary care office visit copay; for vision exam Hardware not covered
30	**CHIROPRACTIC CARE**	$30 copay for 20 visits
31	**SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)**	Travel Clinic for pre-travel health risk assessments, immunizations and prescriptions; Mail-order Pharmacy; post-mastectomy breast reconstruction including services to attain breast symmetry, prostheses and services due to complications; Health education classes including Smoking Cessation, Stress Management, Women's Health and Diet and Nutrition; Special Services Hospice program for persons who have not yet chosen hospice care
PART C: LIMITATIONS AND EXCLUSIONS		
32	**PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED** [5]	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33	**EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?**	No
34	**HOW DOES THE POLICY DEFINE A "PREEXISTING CONDITION"?**	Not applicable. Plan does not exclude coverage for pre-existing conditions
35	**WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?**	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g. employer). Review them to see if a service or treatment you may need is excluded from the policy
PART D: USING THE PLAN		
36	**Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?**	Yes
37	**Is prior authorization required for surgical procedures and hospital care (except in an emergency)?**	Yes
38	**If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?**	No
39	**What is the main customer service number?**	(303) 338-3800
40	**Whom do I write/call if I have a complaint or want to file a grievance** [6]	Customer Service Center 2500 S. Havana Street Aurora, CO 80014 Telephone (303) 338-3800
41	**Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?**	Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42	**To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.**	Policy forms DEDEOC-DENCOS(07-03) and GA-DENCOS(01-03) Large Group
PART E: COST		
43	**What is the cost of this plan?**	

	Employee Portion	**StateContribution**	**FullPremium**
Employee only	$93.64	$156.06	$246.40
Employee + 1 dep.	$263.56	$232.52	$492.78
Employee + 2 or more dep.	$366.74	$326.46	$689.90

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH

Any person interested in applying for coverage, or who is covered by or who purchased coverage under this plan, may request answers to the

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit?

Endnotes:

1. "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2. "Out of Pocket Maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.

3. "Emergency Care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or-limb threatening emergency existed.

4. "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressivedisorder, specific obsessive-compulsive disorder, and panic disorder.

5. Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

6. Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Selected Benefit Descriptions
Colorado Health Plan Description Form Addendum
Kaiser Foundation Health Plan of Colorado
Plan 230
State of Colorado, Group 225

Benefit	Benefit Level
11 PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions	$15 Generic / $40 Brand - prescribed covered drugs on Health Plan's formulary - for up to a 30-day supply for maintenance drugs or part of a 30-day supply for non-maintenance drugs. Certain drugs that have a significant potential for waste and diversion will be provided for up to a 30-day supply, at the applicable prescription drug Copayment, and are not available by mail order service. If a Member requests a name-brand drug when a generic equivalent drug is prescribed, the Member must pay $40.00, plus any difference in price between the preferred generic equivalent drug prescribed or authorized by the Physician and the requested brand drug. If the brand drug is prescribed due to medical necessity, the Member pays only the brand Copayment. **Mail Order Service:** **Denver/Boulder Service Area:** Refills will be mailed through Direct Rx, Kaiser Permanente's mail order prescription service. Refills of prescribed drugs may be obtained for up to a 90-day supply by mail order, at a charge of two prescription drug Copayments. Reorder envelopes are available at any Kaiser Permanente Pharmacy and are included in every prescription order mailed by Direct Rx. Refills will be mailed by first-class U.S. Mail with no charge for postage and handling. Direct Rx can be used 24 hours a day by calling (303) 344-5077. **Colorado Springs Service Area:** Refills of maintenance drugs may be filled by calling our convenient mail order prescription service, ScripPharmacy, which is available 24 hours a day. Contact ScripPharmacy customer service representatives at (800) 677-4323 for more information. Refills will be mailed by first class U.S. Mail with no charge for postage and handling. Maintenance drug refills may be obtained by mail order for up to a 90-day supply, at a charge of two prescription drug Copayments, if prescribed by a Plan Physician. Maintenance drugs are determined by Health Plan.

DPA

Colorado Health Plan Description Form
San Luis Valley
HMO
Effective January 1, 2004

PART A: TYPE OF COVERAGE

1	**TYPE OF PLAN**	HMO
2	**OUT-OF-NETWORK CARE COVERED?** [1]	Only for emergency and urgent care
3	**AREAS OF COLORADO WHERE PLAN IS AVAILABLE**	Plan is available only in the following counties: Alamosa, Conejos, Costilla, Mineral, Rio Grande, and Saguache

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

		IN-NETWORK (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4	**ANNUAL DEDUCTIBLE**	
a)	**Individual**	No Deductibles
b)	**Family**	No Deductibles
5	**OUT-OF-POCKET ANNUAL MAXIMUM** [2]	
a)	**Individual**	2 X annual premium
b)	**Family**	2 X annual premium
6	**LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE**	No lifetime maximum (See Transplants, Line #24)
7 a)	**COVERED PROVIDERS**	All physicians in the San Luis Valley six-county service area; approximately 1,000 specialty providers in Colorado; 15 Colo. hospitals. See provider directory for complete list.
7 b)	**WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 7A. ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?**	Yes
8	**ROUTINE MEDICAL OFFICE VISITS**	$30 per visit copay-PCP $50 per visit copay-Specialist
9	**PREVENTIVE CARE**	
a)	**Children's Services**	$30 per visit copay-PCP $50 per visit copay-Specialist
b)	**Adult's Services**	$30 per visit copay-PCP $50 per visit copay-Specialist
10	**MATERNITY**	
a)	**Prenatal care**	$30 per visit copay-PCP $50 per visit copay-Specialist
b)	**Delivery & inpatient well baby care**	$250 copay per day; up to maximum of $1,000 copay per admis-sion
11	**PRESCRIPTION DRUGS** Level of coverage and restrictions on prescriptions	$15 copay for formulary generic; $40 copay for formulary brand name ; $60 copay for non-formulary brand name and non-formulary generic. Prescriptions are filled at the lesser of a 30-day supply or 100 unit dose. Two copays required for 90-day supply of maintenance drugs through mail order. 20% copay for injectables. For drugs on our approved list, excluded drugs and injectables subject to the 20% copay contact Customer Service. Not subject to out of pocket maximum.
12	**INPATIENT HOSPITAL**	$250 copay per day; up to maximum of $1,000 copay per admission
13	**OUTPATIENT/AMBULATORY SURGERY**	$200 copay per procedure.

14 LABORATORY AND X-RAY **a) Individual** **b) Family**	 $30 copay $150 copay per procedure for MRI/MRA/CT//PET scans.
15 EMERGENCY CARE [3]	$100 copayment per visit (waived if admitted) Emergency Care covered in or out-of-network.
16 AMBULANCE	$20% copay per trip. Not waived if admitted, not included in out-of-pocket maximum.
17 URGENT, NON-ROUTINE, AFTER HOURS CARE	$50 per urgent care visit copay ($100 if in emergency room)Urgent care may be received from your PCP or from an urgent care center. Care covered in or out-of-network.
18 BIOLOGICALLY-BASED MENTAL ILLNESS [4] **CARE**	Coverage is no less extensive than the coverage provided for any other physical illness.
19 0THER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	 50% copay (limited to 45 days) $30 copay per visit (limited to 20 visits)
20 ALCOHOL & SUBSTANCE ABUSE **a) Inpatient** **c) Outpatient**	 50% copay (covered only for short term detoxification, rehabilitation not covered) Limited to one treatment per contract year, two treatments for lifetime. $30 copay per visit (limited to 20 visits)
21 PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY **a) Inpatient care** **b) Outpatient care**	 $250 copay per day up to maximum of $1,000 copay per ad-mission. $30 per visit copay (limited to 30 treatments per injury or ill-ness)
22 DURABLE MEDICAL EQUIPMENT	50% copay (benefit limited to $3,000 benefit payment per cal-endar year, combined with oxygen benefit (line 23), except for prosthetic devices that are not subject to the maximum benefit payment, but does reduce the maximum benefit payment of $3,000.
23 OXYGEN	50% copay (limited to $3,000 benefit payment per calendar year, combined with durable medical equipment benefit (line 22)
24 ORGAN TRANSPLANTS	$250 copay per day, up to maximum of $1,000 copay per admission. Cornea, heart, heart-lung, lung, kidney, kidney-pancreas, liver, bone marrow (only for certain medical conditions), peripheral blood stem cell. $250,000 Lifetime Maximum Benefit.
25 HOME HEALTH CARE	No copay (100% covered) when authorized. Limited to 30 visits per calendar year.
26 HOSPICE CARE	No copay (100% covered) when authorized.
27 SKILLED NURSING FACILITY CARE	No copay (100% covered) when authorized; limited to 30 days per calendar year.
28 DENTAL CARE	No dental benefits are available under this medical plan. How-ever, the State of Colorado offers two separate dental plans for eligible employees and dependents. See other enrollment materials.
29 VISION CARE	$20 per visit copay limited to one visit every 24 months. Hard-ware not covered.
30 CHIROPRACTIC CARE	Not covered.
31 SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Free child car seat program for expectant mothers who meet eli-gibility criteria; Smoking cessation program - $150 lifetime benefit; Infertility Services: for diagnosis only - 50% copay. Hearing Aids – Covered up to $500 once every three (3) years.

PART C: LIMITATIONS AND EXCLUSIONS		
32	**PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED** [5]	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33	**EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?**	No
34	**HOW DOES THE POLICY DEFINE A "PREEXISTING CONDITION"?**	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
35	**WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?**	Exclusions vary by policy. A list of exclusions is available im-mediately upon request from your carrier. Review them to see if a service or treatment you may need is excluded from the policy.
PART D: USING THE PLAN		
36	**Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?**	Yes
37	**Is prior authorization required for surgical procedures and hospital care (except in an emergency)?**	Yes
38	**If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?**	No
39	**What is the main customer service number?**	1-800-475-8466 or 1-719-589-3696
40	**Whom do I write/call if I have a complaint or want to file a grievance** [6]	Complaint & Grievance Coordinator San Luis Valley HMO Inc.700 Main Street, Suite 100 Alamosa, CO 81101 1-800-475-8466 or 1-719-589-3696
41	**Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?**	Colorado Division of Insurance Denver, ICARE Section1560 Broadway, Suite 850 CO 80202
42	**To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.**	Policy Form SLV/SOC2004 Large Group Only

PART E: COST				
43	**What is the cost of this plan?**	**Employee Portion**	**StateContribution**	**FullPremium**
	Employee only	$120.00	$156.06	$272.76
	Employee + 1 dep.	$316.28	$232.52	$545.5 0
	Employee + 2 or more dep.	$440.86	$326.46	$764.02

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH

Any person interested in applying for coverage, or who is covered by or who purchased coverage under this plan, may request answers to the

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit?

Operations ManagerSan Luis Valley HMO, Inc.700 Main, Suite 100Alamosa, CO 811011-800-475-8466 or 1-719-589-3696

Endnotes:

1. "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2. "Out of Pocket Maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.

3. "Emergency Care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or-limb threatening emergency existed

4. "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressivedisorder, specific obsessive-compulsive disorder, and panic disorder.

5. Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

6. Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

DPA

Colorado Health Plan Description Form
PacifiCare
HMO
Effective January 1, 2004

PacifiCare®

PART A: TYPE OF COVERAGE

1	**TYPE OF PLAN**	Health Maintenance Organization (HMO).
2	**OUT-OF-NETWORK CARE COVERED?** [1]	Only for emergency care.
3	**AREAS OF COLORADO WHERE PLAN IS AVAILABLE**	Plan is available only in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Lincoln, Logan, Morgan, Park, Teller, Washington and Weld.

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

		IN-NETWORK (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4	**ANNUAL DEDUCTIBLE**	
	a) **Individual**	No deductibles
	b) **Family**	No deductibles
5	**OUT-OF-POCKET ANNUAL MAXIMUM** [2]	
	a) **Individual**	$2,500 (Per Contract Year)
	b) **Family**	$5,000 (Per Contract Year)
6	**LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE**	No Lifetime Maximum
7 a)	**COVERED PROVIDERS**	5,342 physicians and 45 hospitals in Colorado as of 8/11/2003. See provider directory for complete list.
7 b)	**WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 7A. ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?**	Yes
8	**ROUTINE MEDICAL OFFICE VISITS**	$30 per visit copay for PCP $50 per visit copay for Specialist
9	**PREVENTIVE CARE**	
	a) **Children's Services**	$30 per visit copay for PCP $50 per visit copay for Specialist
	b) **Adult's Services**	$30 per visit copay for PCP $50 per visit copay for Specialist
10	**MATERNITY**	
	a) **Prenatal care**	$30 per visit copay for PCP $30 per visit copay for Specialist
	b) **Delivery & inpatient well baby care**	$250 copayment per day, $1000 maximum copayment per admission.
11	**PRESCRIPTION DRUGS** Level of coverage and restrictions on prescriptions	Available as separate pharmacy plan or as an optional benefit if purchased by your employer, see benefit schedule attached (if applicable).
12	**INPATIENT HOSPITAL**	$250 copayment per day, $1000 maximum copayment per admission.
13	**OUTPATIENT/AMBULATORY SURGERY**	$125 copayment per visit.
14	**LABORATORY AND X-RAY**	No copayment (100% covered); MRI, CT, SPECT and PET Scan $100 copayment per procedure.

15	**EMERGENCY CARE** [3]	Emergency room setting inside and outside the service area: $100 copayment per visit. Urgent Care and Follow-up care to emergency services received outside the HMO service area is covered to a maximum of $400 per contract year.
16	**AMBULANCE**	$100 copayment per episode inside and outside the service area.
17	**URGENT, NON-ROUTINE, AFTER HOURS CARE**	$100 copayment in emergency room setting inside and outside the service area; otherwise $50 copayment per visit. Urgent Care and Follow-up care to emergency services received outside the HMO service area is covered to a maximum of $400 per contract year.
18	**BIOLOGICALLY-BASED MENTAL ILLNESS** [4] **CARE**	Coverage is no less extensive than the coverage provided for any other physical illness.
19	**OTHER MENTAL HEALTH CARE**	
	a) Inpatient care	50% per admission; coverage for maximum of 45 full or 90 partial days per
	b) Outpatient care	$30 copayment for visits 1-5 $50 copayment thereafter.
20	**ALCOHOL & SUBSTANCE ABUSE**	
	a) Inpatient	50% of allowed charges, coverage for maximum of 45 full or 90 partial days per contract year.
	c) Outpatient	$30 copayment for visits 1-5, $50 copayment thereafter. Limited to one course of treatment per contract year, two courses of treatment during the member's lifetime.
21	**PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY**	Physical/Occupational: $30 copayment per visit, coverage for maximum of 20 sessions per acute condition. Speech Therapy: $30 copayment per visit, coverage for maximum of 20 sessions for certain acute conditions. For children born with congenital defects or birth abnormalities up to age 5, 20 visits each of physical, occupational and speech therapy per contract year; $30 copayment per visit.
22	**DURABLE MEDICAL EQUIPMENT**	Coverage for maximum of $3,000 per member per contract year, including oxygen. Coverage is limited to certain items. Orthopedic Braces and Podiatric Shoe Inserts are limited to a separate combined $500 maximum. Surgical bras meeting criteria are covered up to $500 per contract year. Prosthetic arms and legs will not be limited to the DME maximum; 80%.
23	**OXYGEN**	No copayment. Covered as durable medical equipment. (see #22)
24	**ORGAN TRANSPLANTS**	Bone marrow (for certain conditions), cornea, liver (for children) and kidney transplants, and skin grafts, are covered based on criteria. Heart, heart/lung (combined), lung, kidney/pancreas (combined), and adult liver transplants, are covered based on criteria. (see #32).
25	**HOME HEALTH CARE**	No copay (100% covered)
26	**HOSPICE CARE**	No copay (100% covered)
27	**SKILLED NURSING FACILITY CARE**	No copayment. Covered up to 30 days per contract year.
28	**DENTAL CARE**	Available as a separate dental care plan or as an optional benefit.
29	**VISION CARE**	$30 copayment per visit; one visit per 12 months.
30	**CHIROPRACTIC CARE**	Available as a separate chiropractic care plan or as an optional benefit.
31	**SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)**	Infertility treatment, 50% copayment; allergy injections, $5 copayment; well-woman exam, $30 copayment; injectables for home use, $75; cardiac rehabilitation covered to $1,000 within a 90-day period.

PART C: LIMITATIONS AND EXCLUSIONS		
32	**PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED** [5]	Not applicable; plan does not impose limitation periods for pre-existing conditions.
33	**EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?**	No
34	**HOW DOES THE POLICY DEFINE A "PREEXISTING CONDITION"?**	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.
35	**WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?**	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.
PART D: USING THE PLAN		
36	**Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?**	Yes
37	**Is prior authorization required for surgical procedures and hospital care (except in an emergency)?**	Yes
38	**If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?**	No
39	**What is the main customer service number?**	Please call Customer Service at (800) 877-9777
40	**Whom do I write/call if I have a complaint or want to file a grievance** [6]	Write to: PacifiCare of Colorado Member Appeals Team, P.O. Box 6770, Englewood, CO 80155
41	**Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?**	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, CO 80202
42	**To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.**	Policy Form #: 19B34 – State of Colorado, Large Group
43	**Does the plan have a binding arbitration clause?**	Yes

PART E: COST

44 What is the cost of this plan?

	Employee Portion	StateContribution	FullPremium
Employee only	$240.94	$156.06	$393.70
Employee + 1 dep.	$558.20	$232.52	$787.42
Employee + 2 or more dep.	$779.24	$326.46	$1,102.40

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH

Any person interested in applying for coverage, or who is covered by or who purchased coverage under this plan, may request answers to the

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit?

Endnotes:

1. "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2. "Out of Pocket Maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.

3. "Emergency Care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or-limb threatening emergency existed

4. "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressivedisorder, specific obsessive-compulsive disorder, and panic disorder.

5. Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

6. Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Selected Benefit Descriptions
Attachment R – Outpatient Prescription Drug Benefit
Colorado Health Plan Description Form Addendum

PacifiCare of Colorado

Pharmacy Plan 117R4

Benefit		Benefit Level
11	**PRESCRIPTION DRUGS**	$15 formulary generic, $40 formulary brand-name, $60 non-formulary. If brand-name is dispensed when a generic equivalent is available and listed on the drug formulary, member pays the non-formulary copayment for the brand name medication.
	Level of coverage and restrictions on prescriptions	Prepackaged units will have one applicable copayment apply per prepackaged unit. PacifiCare does require prior authorization for specific prescription drugs. A 90-day supply of maintenance medications, or a three-cycle maximum of oral contraceptives, is available through the mail-order prescription pharmacy for two applicable copayments. Prepackaged units dispensed through the mail-order prescription pharmacy will have one applicable copayment apply per two prepackaged units. For more information on the mail-order prescription drug program, or for information on drugs on our approved formulary list, call Customer Service at (800) 877-9777. *NOTE*: PacifiCare's prescription drug coverage relies on a framework provided by a drug *formulary*. Quite simply, a formulary is a list of preferred or recommended drugs that have been carefully selected by physicians and pharmacists based upon the safety and effectiveness of those drugs. You pay your applicable copayment for prescriptions filled at network pharmacies: • Formulary Generic • Formulary Brand • Formulary Brand

The state currently offers two dental plans: Delta Basic and Delta Basic Plus. The state pays the premium for its eligible employees under the Delta Basic plan. Employees who wish to upgrade to the Delta Basic Plus plan are responsible for paying the difference in rates.

Employees can also purchase dental coverage for their eligible dependents. Dependent children under the age of five are covered through the employee's plan at no cost to the employee for both Delta Basic and Delta Basic Plus. Dependents under five still must be listed as such on the dental benefit enrollment form.

The no cost coverage for children under age five automatically terminates the end of month he or she turns five. If the employee wishes to continue the child's coverage after he or she turns five, the employee MUST complete a new enrollment change form regardless of coverage level and submit to the appropriate payroll/personnel staff before the end of the month in which the child turns five.

Statewide Plans
Delta Basic
Delta Basic Plus

Plans	Carrier Premium Rates	State Contribution	Total Employee Cost
Delta Dental Basic			
Employee	$ 16.26	$ 16.26	**$ -**
Employee +1	$ 36.92	$ 16.26	**$ 20.66**
Employee +2	$ 58.00	$ 16.26	**$ 41.74**
Delta Dental Basic Plus			
Employee	$ 24.34	$ 16.26	**$ 8.08**
Employee +1	$ 53.90	$ 16.26	**$ 37.64**
Employee +2	$ 100.48	$ 16.26	**$ 84.22**

Delta Dental Basic/Basic Plus Plans

No benefit changes for 2004.

Clarification for children under age five (5): Free coverage for children under age five (5) automatically terminates end of month he/she turns age five (5). If the employee wishes to continue the child's coverage after he/she turns age five (5), the employee MUST complete a new enrollment/change form regardless of coverage level.

STATE OF COLORADO
Delta Preferred Option Plan***BASIC***
Group #006784

EFFECTIVE JANUARY 1, 2004

DPA

MAXIMUM: Per enrolled family member Calendar year $850.00	**DEDUCTIBLE:** $50.00 per family member calendar year deductible. The deductible is waived for Diagnostic and Preventive Services.

PREVENTIVE AND DIAGNOSTIC SERVICES	
• **DPO: 100%** • **NON-DPO: 100%** (of maximum allowable fee)	**Oral Exam:** 2 in a calendar year **Bitewing X-rays: 2** sets in a calendar year **Full Mouth X-rays:** 1 in 36 months **Routine Cleaning:** 2 in a calendar year **Fluoride Treatments:** 2 in a calendar year, under age **15** **Space Maintainers:** under age **19** **Sealants:** under age **15** on unrestored, noncarious permanent molars, but not more than once in any 36 month period Emergency treatment for relief of pain
BASIC SERVICES	
• **DPO: 50%** • **NON-DPO: 50%** (of maximum allowable fee)	**Restorative:** Amalgam Fillings Resin, Composite Fillings (anterior teeth only) **Oral Surgery:** Simple Extractions, Surgical Extractions (including wisdom teeth), General Anesthesia **Periodontics:** Periodontal Cleanings (subject to special need), Periodontal Surgery (including gingivectomy), Scaling and Root Planing, Gingival Curettage **Endodontics:** Root Canal Therapy
MAJOR SERVICES	
• **DPO: 50%** • **NON-DPO: 50%** (of maximum allowable fee)	**Major Restorative:** Crowns, Inlays, and Onlays - when teeth cannot be restored with regular fillings **Prosthodontics:** Dentures, Partials, Fixed Bridges and Crowns (when part of the bridge) **Prosthodontics Maintenance:** Bridge or Denture Repair, Rebase or Reline of Dentures, Re-cement of Crowns, Inlays and Onlays

Dependent Children covered to the end of year in which the child attains age 19
Full-time Students covered to the end of the month in which the child attains age 24

The Open Enrollment period is normally October-November of every year. At this time employees will have the opportunity to switch between plans. Dependents under age five are covered under the dental plan at no premium cost to the employee. During the month a dependent reaches age five, the child must be added to the employee(s) dental coverage (even if already at family) and pay premium in order to continue coverage.

This is just a brief description of the dental plan designed for the State of Colorado.

IMPORTANT: YOU WILL PAY ADDITIONAL OUT OF POCKET EXPENSES WHEN YOU SEE A NON-DPO DENTIST!

MAXIMUM ALLOWABLE FEE IS BASED ON A PRE-ARRANGED DISCOUNTED FEE SCHEDULE.

STATE OF COLORADO
Delta Preferred Option Plan***BASIC PLUS***
Group #006785

EFFECTIVE JANUARY 1, 2004

MAXIMUM: Per enrolled family member calendar year: $1,200.00 Orthodontic Lifetime Max: $1,000.00	**DEDUCTIBLE:** $50.00 per person calendar year; $150.00 per family. The deductible is waived for Diagnostic, Preventive and Orthodontia.

PREVENTIVE AND DIAGNOSTIC SERVICES	
• **DPO: 100%** • **NON-DPO: 100%** (of maximum allowable fee)	**Oral Exam:** 2 in a calendar year **Bitewing X-rays: 2** sets in a calendar year **Full Mouth X-rays:** 1 in 36 months **Routine Cleaning:** 2 in a calendar year **Fluoride Treatments:** 2 in a calendar year, under age **15** **Space Maintainers:** under age **19** **Sealants:** under age **15** on unrestored, noncarious permanent molars, but not more than once in any 36 month period Emergency treatment for relief of pain
BASIC SERVICES	
• **DPO: 80%** • **NON-DPO: 80%** (of maximum allowable fee)	**Restorative:** Amalgam Fillings Resin, Composite Fillings (anterior teeth only) **Oral Surgery:** Simple Extractions, Surgical Extractions (including wisdom teeth), General Anesthesia **Periodontics:** Periodontal Cleanings (subject to special need), Periodontal Surgery (including gingivectomy), Scaling and Root Planing, Gingival Curettage **Endodontics:** Root Canal Therapy
MAJOR SERVICES	
• **DPO: 50%** • **NON-DPO: 50%** (of maximum allowable fee)	**Major Restorative:** Crowns, Inlays, and Onlays - when teeth cannot be restored with regular fillings **Prosthodontics:** Dentures, Partials, Fixed Bridges and Crowns (when part of the bridge) **Prosthodontics Maintenance:** Bridge or Denture Repair, Rebase or Reline of Dentures, Re-cement of Crowns, Inlays and Onlays
ORTHODONTICS	
• **50%**	Complete Orthodontic Exam (including necessary x-rays) Active Orthodontic Treatment. Orthodontic benefits provided for children under age 19

Dependent Children covered to the end of year in which the child attains age 19
Full-time Students covered to the end of the month in which the child attains age 24

The Open Enrollment period is normally October-November of every year. At this time employees will have the opportunity to switch between plans. Dependents under age five are covered under the dental plan at no premium cost to the employee. During the month a dependent reaches age five, the child must be added to the employee(s) dental coverage (even if already at family) and pay premium in order to continue coverage.

This is just a brief description of the dental plan designed for the State of Colorado.
IMPORTANT: YOU WILL PAY ADDITIONAL OUT OF POCKET EXPENSES WHEN YOU SEE A NON-DPO DENTIST!

MAXIMUM ALLOWABLE FEE IS BASED ON A PRE-ARRANGED DISCOUNTED FEE SCHEDULE.

Employees who want to change from pre-tax to post-tax or vise versa must use the on-line enrollment system to do so. New this year, employees will be able to choose pre-tax and post-tax options separately for both dental and medical insurance. Mid-year changes from pre-tax to post-tax and vice versa are not permitted.

Pre-tax premiums do affect your highest average salary (HAS) with PERA. Thus, employees within three years of PERA retirement should carefully consider pre-tax contributions to an FSA.

Consider Pre-tax or After-tax Deductions
If you select medical and/or dental coverage, you may elect to have your share of the premium deducted on a pre-tax basis under the premium conversion provisions of the State's Section 125 Salary Reduction Plan. Your take-home pay will be greater because federal and state income taxes, your PERA contribution, and the Medicare Tax (where applicable) will be based on your reduced salary. The higher your income tax bracket, the greater your savings will be.

How Section 125 Affects PERA Benefits
Your disability and retirement benefits through the Public Employees Retirement Association (PERA) are based on the average of your three Highest Annual Salaries (HAS). Since PERA contributions are calculated as a percentage of salary, the monthly contributions to your PERA account are reduced to the extent that your salary is reduced by pre-tax premium contributions. PERA benefits are affected when the Pre-tax Premium option is selected during the three years of HAS, but are not be affected by selecting the pre-tax premium option in other years. In other words, if the salaries used to calculate your HAS are from periods in which you participated in the Section 125 Salary Reduction Plan, the PERA benefit amount paid to you will be lower than if you were not participating in the plan.

Review your Selection Annually
If you elect the Pre-tax Premium option, your election will continue automatically from year to year unless you change your option during the regularly scheduled annual open enrollment period. Mid-year or retroactive election changes are not permitted. If you are within three years of retirement, take time to consider whether or not you should participate in the Section 125 Salary Reduction Plan. For more information about how Section 125 salary reductions affect your PERA benefits, call PERA Customer Service at 303-832-9550 or 1-800-759-7372.

Pre-tax Premium Elections are Irrevocable during the Plan Year
If you choose the Pre-tax Premium option, your election is generally irrevocable during the plan year. Refer to *Exceptions to the Irrevocability Rules* at www.colorado.gov/dpa/dhr/benefits/2004 for information regarding the limited circumstances under which you may be permitted to change your election. If you wish to retain the option to cancel your coverage during the plan year, do not elect Pre-tax Premium.

Flexible spending accounts (FSA) may be an excellent way to help alleviate healthcare and dependent care costs. An FSA allows you to set aside money on a pre-tax basis, lowering your taxable income. These pre-tax dollars can be used to cover healthcare and dependent care expenses.

Employees must re-enroll in an FSA every year during open enrollment, and are committed through the year (see *Exceptions to Irrevocability Rules* at www.colorado.gov/dpa/dhr/benefits/2004 for the few exceptions). Use the worksheet on page 33 to help decide if a Healthcare FSA is right for you. You can estimate dependent care expenses in a similar way to help decide if a Dependent Care FSA is right for you.

FSAs do affect your HAS with PERA. Thus, employees within three years of a PERA retirement should carefully consider pre-tax contributions to an FSA.

What is a flexible spending account and how can it help me control my healthcare costs?
An FSA allows you to set aside money on a pre-tax basis, lowering your taxable income. You can then use that money to cover health care and dependent care expenses. An FSA will not directly lower or control your health care costs, but using an FSA will put more money in your pocket to pay for those costs. Flexible spending accounts are funded by salary reductions, commonly referred to as "contributions." Each year you choose the amount you wish to "contribute." This amount is also called your annual election. Your payroll deduction is calculated by dividing your annual election by the number of paychecks you receive in a year. You must make separate elections for your health care flexible spending account and your dependent care flexible spending account.

Central Bank/ASI administers the State's FSA plans. You may want to check out ASI's website at www.asiflex.com. There is a great deal of detailed information published there. Participants may check the status of their FSAs from the ASI website using the PIN provided on their enrollment confirmation. Alternatively, accounts may be accessed via telephone at 1 800-366-4827. At the prompt, press 2 for balance or disbursement information. Press 1 to speak with a representative.

Are all medical expenses eligible for reimbursement?
No, but most medical expenses not reimbursed by insurance can be reimbursed from your health care FSA. Any expense that qualifies under Section 213(d) of the Internal Revenue Code (except insurance premiums and long-term care expenses) qualifies. You may download Internal Revenue Publication 502 Medical and Dental Expenses – www.irs.gov/pub/irs-pdf/p502.pdf from the IRS website. The list ofeligible expenses changes over time. If you haven't reviewed the list recently, you may want to take another look. Please note that whereas the IRS requires expenses be "paid" within the tax year to be deductible, expenses must be "incurred" during the plan year in order to be eligible for reimbursement from a FSA.

Important Note: Although the IRS recently reversed its position and now permits flexible spending account plans to allow reimbursement of some over-the-counter drugs, the State's plan does not currently allow reimbursement of non-prescription drugs. Although it is likely that the plan will be amended to accommodate this new ruling, the change may not be in place prior to the beginning of the plan year.

Are all dependent care expenses eligible for reimbursement?
No, but expenses that qualify under Internal Revenue Code Section 21(b)(2) for the Child Care Credit will qualify for reimbursement. If you pay someone to care for a child under the age of 13 or for a

family member that cannot care for himself or herself (e.g. a disabled or elderly adult tax dependent) so you can work, the cost of care may be reimbursed from your dependent care flexible spending account. Download Internal Revenue Publication 503 Child and Dependent Care Expenses – www.irs.gov/pub/irs-pdf/p503.pdf for more information. If you file for the child care tax credit with your tax return, you may still be eligible to participate in the dependent care flexible spending account, depending upon your income level and the amount of care expenses you expect to incur. You may want to consult your tax advisor before making an election.

Please note that whereas the IRS requires expenses be "paid" within the tax year to be deductible, expenses must be "incurred" during the plan year in order to be eligible for reimbursement from a flexible spending account.

How much can I save?
The amount you can save depends upon your tax bracket and the amount of your election If, for example, your combined federal and state income tax rate is 22%, you will save approximately $22 in taxes per $100 of annual election. Account balances are forfeited at the end of the year.

Why can't the money be returned to me?
FSAs are subject to IRS Section 125 rules and regulations. Under current law, an employer is prohibited from refunding or carrying over an individual's FSA balance from one plan year to the next.

I have heard that Healthcare Reimbursement Accounts can be carried forward. Is this true?
Despite the similar name and purpose, "Healthcare Reimbursement Accounts"(HRA's) are not the same thing as "Health Care Flexible Spending Accounts" and are not subject to Section 125 of the Internal Revenue Code. One major difference is that Healthcare Reimbursement Accounts are funded with employer contributions while FSAs are funded with employee contributions (salary reductions). The Healthcare Reimbursement Account is an integral feature of many "defined contribution" medical plans, a type of self-funded plan we are currently investigating.

Can I change my election mid-year?
Maybe. Although the State's FSA plan allows a participant to change his or her election in response to certain "qualifying events," the Section 125 rules and regulations are quite stringent. The proposed change must be consistent with the qualifying event. For example, a request to increase an election would be consistent with an addition to the family (e.g. birth or marriage), whereas a reduction in an election would be consistent with a loss (e.g. divorce or death). Changes permitted under Section 125 may or may not be permitted by the State's FSA plan (the State plan is amended from time to time as the federal regulations change).

	Healthcare FSA	Dependent Care FSA
Maximum Annual Contribution	$6,000	If single, the lesser of the Participant's earned income for the year or $5000. If married, the lesser of the Participant's or the Spouse's earned income for the year or $5000 if filing jointly, $2500 if filing separately.
Special Rule if Spouse is Full-time Student	Not applicable	For each month during which spouse is a full-time student, spouse shall be considered to be gainfully employed and earning income of not less than $250 a month ($3000 a year) if there is one Eligible Dependent, or $500 a month ($6000 a year) if there are two or more Eligible Dependents.
Special Rule if Spouse is Incapable of Self-Care.	Not applicable	For each month during which spouse is incapable of caring for him/herself, spouse shall be considered to be gainfully employed and earning income of not less than $250 ($3000 a year) if there is one Eligible Dependent or $500 ($6000 a year) if there are two or more Eligible Dependents.
Minimum Monthly Contribution (note: to accommodate bi-weekly payroll, monthly contribution must be an even number, payroll will round down odd contributions)	$10	$10
Positive Election Required	Employee must make a new election each Plan Year. A currently participating employee who fails to re-enroll during Open Enrollment will NOT be covered.	Same as Health Care FSA
Irrevocability Rule	Annual Elections are irrevocable and cannot be changed after the beginning of the plan year except as specifically provided in the State's Salary Reduction Plan Document, in accordance with federal Section 125 regulations. See Exceptions to Irrevocability Rules – Mid-Year Changes	Same as Health Care FSA
Eligible Expenses	Medical care, as defined in Section 213(d) of the Internal Revenue Code, excluding (i) premiums for any health insurance plan, policy or contract, or (ii) long-term care expenses and (iii) any expense which has been reimbursed, or is reimbursable from any Expense must also be excludable from income pursuant to IRC Section 129. Expense must be incurred during the Plan Year and in a month during which a contribution is made. Expense must be incurred by Participating Employee or Eligible Dependent	Dependent care expenses for the care of an Eligible Dependent, limited to the household and dependent care services necessary for gainful employment as provided in IRC Section 21(b)(2) in accordance with IRC Section 129. [see www.asiflex.com for discus Expense must be incurred during the Plan Year and in a month during which a contribution is made. Expenses incurred in any month in which the Employee or Spouse is not gainfully employed are not eligible expenses.

DESCRIPTION		
Definition of "Eligible Employee"	The definition found in Colorado Revised Statutes 24-50-603(7), "Definitions," as amended. Employee does not include persons employed on a temporary basis.	Same as Health Care FSA
Definition of "Eligible Dependent"	The spouse and each unmarried child or step-child of a participating Employee, or any other relative or household member whom the Participant may claim as a dependent for federal income tax purposes in accordance with IRC Section 152 for the Plan Year in	Same as Health Care FSA. An Eligible Dependent must also qualify as a "qualifying individual" as specified in IRC Section 21(b)(1) [may be claimed as a dependent on tax return]
Request for Reimbursement	Submit a request for reimbursement (claim form) and documentation. to ASI, P.O. Box 6044, Columbia, MO 65205-6044. Download from www.asiflex.com.	Same as Health Care FSA Download from www.asiflex.com.
Documentation Required	An Explanation of Benefits from Insurance Carrier, or an Itemized Bill from Health Care Provider that includes: *Patient Name *Date of Service *Amount of Charge *Description of Service *Provider Name and Tax ID *Additional information as may be required to adjudicate the claim (as determined by the plan administrator) .	Itemized Bill from Dependent Care Provider that includes: *Dependent Name *Date of Service *Amount of Charge *Description of Service *Provider Name and Tax ID *Additional information as may be required to adjudicate the claim (as determined by the plan administrator)
Continuation under COBRA	If on the date of the qualifying event, there is a positive balance in the account (contributions exceed reimbursements), Participant may apply for continuation under COBRA. Coverage under COBRA may be continued through the end of the Plan Year, subject	Not available.
Deadline for submission of reimbursement requests.	Complete claims must be postmarked not later than April 15 following the end of the Plan Year.	Same as Health Care FSA
Maximum Benefit	100% of a unreimbursed, eligible medical expenses, not to exceed Participant's Annual Contribution for the Plan Year	100% of eligible dependent care expenses, not to exceed the balance available in the account at any given time.

Healthcare Worksheet

Estimating your healthcare expenses

* Enter your health care expenses for the last 12 months.
* Enter your known or expected expenses for the next 12 months.

Eligible Expenses	Expenses Incurred in 2003	Expected Expenses for 2004
Health Care Expenses:		
Deductibles	$	$
Coinsurance	$	$
Copayments	$	$
Amounts above plan limits	$	$
Other health care expenses not reimbursed by your medical	$	$
Dental Expenses:		
Deductibles, copayments	$	$
Coinsurance	$	$
Other dental expenses not reimbursed by your dental plan	$	$
Vision & Hearing Expenses (above plan maximums):		
Eye exams	$	$
Corrective contact lenses	$	$
Prescription eyeglasses	$	$
Hearing exams	$	$
Hearing aids or devices	$	$
TOTAL EXPENSES	**$**	**$**
2004 Monthly Contribution		**$**

The state provides $12,000 of Basic Life and Accidental Death and Dismemberment (AD&D) coverage at no cost to you. You may also apply for up to $300,000 of Optional Life and AD&D coverage for yourself in $10,000 increments. And, if you apply for Optional Life and AD&D, you may also apply for up to $10,000 Children Optional Life and AD&D coverage in $5,000 increments. The employee must have at least $20,000 of Optional Life in order to purchase the $10,000 maximum for children.

Employee/Spouse Optional Life/AD&D Premiums by Insurance Amount and Age

Insurance Amount	Under 20	Age 20-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70 & Over
$10,000	0.76	0.80	0.84	1.04	1.16	1.40	2.00	3.18	5.18	9.62	15.84	28.30
$20,000	1.52	1.60	1.68	2.08	2.32	2.80	4.00	6.36	10.36	19.24	31.68	56.60
$30,000	2.28	2.40	2.52	3.12	3.48	4.20	6.00	9.54	15.54	28.86	47.52	84.90
$40,000	3.04	3.20	3.36	4.16	4.64	5.60	8.00	12.72	20.72	38.48	63.36	113.20
$50,000	3.80	4.00	4.20	5.20	5.80	7.00	10.00	15.90	25.90	48.10	79.20	141.50
$60,000	4.56	4.80	5.04	6.24	6.96	8.40	12.00	19.08	31.08	57.72	95.04	169.80
$70,000	5.32	5.60	5.88	7.28	8.12	9.80	14.00	22.26	36.26	67.34	110.88	198.10
$80,000	6.08	6.40	6.72	8.32	9.28	11.20	16.00	25.44	41.44	76.96	126.72	226.40
$90,000	6.84	7.20	7.56	9.36	10.44	12.60	18.00	28.62	46.62	86.58	142.56	254.70
$100,000	7.60	8.00	8.40	10.40	11.60	14.00	20.00	31.80	51.80	96.20	158.40	283.00
$110,000	8.36	8.80	9.24	11.44	12.76	15.40	22.00	34.98	56.98	105.82	174.24	311.30
$120,000	9.12	9.60	10.08	12.48	13.92	16.80	24.00	38.16	62.16	115.44	190.08	339.60
$130,000	9.88	10.40	10.92	13.52	15.08	18.20	26.00	41.34	67.34	125.06	205.92	367.90
$140,000	10.64	11.20	11.76	14.56	16.24	19.60	28.00	44.52	72.52	134.68	221.76	396.20
$150,000	11.40	12.00	12.60	15.60	17.40	21.00	30.00	47.70	77.70	144.30	237.60	424.50
$160,000	12.16	12.80	13.44	16.64	18.56	22.40	32.00	50.88	82.88	153.92	253.44	452.80
$170,000	12.92	13.60	14.28	17.68	19.72	23.80	34.00	54.06	88.06	163.54	269.28	481.10
$180,000	13.68	14.40	15.12	18.72	20.88	25.20	36.00	57.24	93.24	173.16	285.12	509.40
$190,000	14.44	15.20	15.96	19.76	22.04	26.60	38.00	60.42	98.42	182.78	300.96	537.70
$200,000	15.20	16.00	16.80	20.80	23.20	28.00	40.00	63.60	103.60	192.40	316.80	566.00
$210,000	15.96	16.80	17.64	21.84	24.36	29.40	42.00	66.78	108.78	202.02	332.64	594.30
$220,000	16.72	17.60	18.48	22.88	25.52	30.80	44.00	69.96	113.96	211.64	348.48	622.60
$230,000	17.48	18.40	19.32	23.92	26.68	32.20	46.00	73.14	119.14	221.26	364.32	650.90
$240,000	18.24	19.20	20.16	24.96	27.84	33.60	48.00	76.32	124.32	230.88	380.16	679.20
$250,000	19.00	20.00	21.00	26.00	29.00	35.00	50.00	79.50	129.50	240.50	396.00	707.50
$260,000	19.76	20.80	21.84	27.04	30.16	36.40	52.00	82.68	134.68	250.12	411.84	735.80
$270,000	20.52	21.60	22.68	28.08	31.32	37.80	54.00	85.86	139.86	259.74	427.68	764.10
$280,000	21.28	22.40	23.52	29.12	32.48	39.20	56.00	89.04	145.04	269.36	443.52	792.40
$290,000	22.04	23.20	24.36	30.16	33.64	40.60	58.00	92.22	150.22	278.98	459.36	820.70
$300,000	22.80	24.00	25.20	31.20	34.80	42.00	60.00	95.40	155.40	288.60	475.20	849.00

Above premiums are individual premiums. If you select coverage for both you and your spouse, the total premium amount will be the cost for you plus the cost for your spouse.
Note: Spouse coverage limited to not more than half of Employee coverage, up to $150,000.

Optional Life/AD&D Insurance Plan Rates for Dependent Children

One monthly premium covers all of your eligible children for the Optional Life insurance amount selected. This coverage must be cancelled when your last eligible dependent child reaches the maximum age. A Child may not be insured by more than one Member, except in the event the Members are divorced from each other. Double coverage is not allowed.

Plans	Coverage Amount	Total Employee Cost
Plan 05		
Child: Birth to 19 years (24 if full-time student)	$ 5,000	**$ 1.24**
Plan 010		
Child: Birth to 19 years (24 if full-time student)	$ 10,000	**$ 2.48**

Standard Life Insurance Company awarded GTL/AD&D contract
Effective January 1, 2004, the State's Group Term Life and AD&D coverage will be underwritten by Standard Insurance Company. Although the benefits are substantially the same as in the current basic life and optional life plans, there are a couple of notable improvements:

- The Standard Life Insurance plan includes a limited Portability of Insurance provision for insured employees and dependents.
- Disability Waiver of Premium benefits will be automatically offered to employees when they are disabled longer than six months. Disabled employees will no longer need to submit a formal application for waiver of premium benefits.
- Should you die, your Dependent Life Insurance coverage will be extended for five months at no cost.
- The new Certificate of Coverage is available online for your review.

Why isn't Guarantee Issue offered at open enrollment anymore?
The State's prior practice of offering guaranteed issue at open enrollment caused adverse selection against the plan and increased premiums. By limiting guarantee issue, the State was able to hold down the Optional Life rates for 2004.

Will Guarantee Issue be available at all?
Yes. Employees who apply within thirty days of their initial eligibility (i.e. date of hire) will be offered the opportunity to purchase up to $60,000 of Optional Life without evidence of insurability. Their Spouse may purchase up to half of that amount without evidence of insurability. Additionally, when an Employee marries, has a baby or adopts, he/she may apply for up to $60,000 and the Spouse may apply for up to $30,000 within 31 days of the event without evidence of insurability. An Employee may also apply for Dependent Child life insurance benefits at the same time. An Employee or Spouse may apply for more than the guaranteed issue amount but a Medical History Statement must accompany the application.

Why is a spouse's coverage limited?
When we analyzed death claims, it was apparent that claims for spouses were disproportionately greater than for employees. The disparity may be due to the "actively at work" requirement which applies to employees but cannot be applied to spouses. By limiting spouse coverage to fifty percent of employee coverage, we feel we can balance the risk of adverse selection by encouraging healthy employees who might not otherwise enroll to do so. We did not want to eliminate guarantee issue altogether.

My spouse currently has optional life insurance. Can she keep it, or do I now have to apply?
Current levels of coverage are "grandfathered" but upgrades (or downgrades) will be subject to the new rules. By way of example, assume you and your spouse currently each have $20,000 of optional life. You may keep it that way if you choose, but if your spouse now wants to apply for $50,000, you must apply for and be issued at least $100,000.

My spouse is healthy, but I am not. What if I am not approved for additional coverage?
Your spouse will not be issued more than half of the amount issued to you even if he/she is healthier than you.

EMPLOYEE	
Basic Life and AD&D	**$12,000** **State pays 100%**
Optional Life and AD&D	**Up to $300,000 in $10,000 increments** **Employee pays 100%** **Proof of Insurability Required***
SPOUSE	
Optional Life and AD&D	**Up to $150,000 in $10,000 increments, but not more than half of the amount issued to Employee.** **Employee pays 100%** **Proof of Insurability Required ***
CHILDREN	
Optional Life and AD&D	**Up to $10,000 in $5,000 increments** **Employee must also be enrolled in Optional Life**

Basic Life and AD&D
The state provides $12,000 of Basic Life and Accidental Death and Dismemberment (AD&D) coverage at no cost to you. Although coverage is automatic, you must complete and sign the enrollment/change form to designate a beneficiary(ies). Submit the form directly to your agency payroll or personnel administrator.

Employee/Spouse Optional Life and AD&D Coverage
You may apply for up to $300,000 of Optional Life and AD&D coverage for yourself in $10,000 increments. In the event of accidental death, your beneficiaries will receive twice the face amount. If you apply for Optional Life and AD&D for yourself, you may also apply for up to half of the face amount issued to you for your spouse, in $10,000 increments. Your coverage must be approved for your spouse coverage to be approved.

Premiums are based upon the age of each insured. The State's Optional Life plan is not part of the Salary Reduction Plan. Premiums contributions do not reduce your taxable income and do not affect your PERA benefits. The death benefits are not taxable as income.

To enroll, change coverage amount, or change your beneficiary designation, you must complete the enrollment/change form. You must also complete a Medical History Statement for each adult applicant. Unlike the enrollment/change form, which is submitted to your payroll/personnel administrator, the Medical History Statement should be mailed directly to Standard Insurance Company at

Standard Insurance Company
Medical Underwriting
900 SW Sixth Avenue
Portland, OR 97204-1282

If approved, coverage will be effective on the first of the month following approval, subject to the Active at Work provisions of the policy.

Dependent Children Optional Life and AD&D
If you apply for Optional Life and AD&D you may also apply for up to $10,000 Children Optional Life and AD&D coverage in $5,000 increments, not to exceed half of the amount issued to you. One

monthly premium covers all of your eligible children, including full-time students up to age 24 and disabled dependent children. You may apply for Dependent Children Life and AD&D within 31 days after your initial eligibility, during open enrollment, or within 31 days after a Life Change Event (marriage, birth or adoption).

Guaranteed Issue
*Evidence of Insurability is not required under the following circumstances:
1) You are enrolled in the Basic Life / AD&D Plan only.
2) You are applying for no more than $60,000 for yourself and $30,000 for your spouse within 31 days after your initial eligibility (i.e., date of hire).
3) You are applying for no more than $60,000 for yourself and $30,000 for your spouse within 31 days after a Life Change Event (marriage, birth, or adoption)
4) You have Optional Life coverage for yourself already and you are applying for Children's coverage only.

When Guaranteed Issue applies, coverage will be effective on the first of the month following date of hire, or date of marriage, birth or adoption, subject to the Active at Work provisions of the policy. Premiums will be payable from the first of the month following your date of hire or Life Change Event, providing your application is timely.

Double Coverage Is Not Allowed
If your spouse is also a state employee, you may elect to be covered as an employee or as a spouse, but not both. Only one of you may apply for coverage for your children. If you are divorced and your former spouse is also a state employee, both of you may elect Optional Dependent Life and AD&D for your children.

Certificate of Coverage
The Certificate of Coverage, which encompasses both Basic and Optional Life plans is available on the Benefits website. New enrollees will receive a hard copy of the Certificate of Coverage by mail.

Beneficiary Designations
If your insured spouse or child dies, the life insurance benefits will be payable to you, if you are living. If you are not living, the benefits will be paid to the survivors in accordance with the policy provisions. You may name more than one beneficiary in a class. The beneficiary designation applies to both the Basic Life and Optional Life benefits under the policy. If only one beneficiary in a class survives, that beneficiary will receive all of the death benefit. A secondary (contingent) beneficiary receives benefits ONLY if there are no surviving primary beneficiaries.
See the Benefit Payment and Beneficiary Provisions in the Certificate of Coverage for additional information.

Active at Work Provisions
If you are incapable of active work because of sickness, injury or pregnancy on the day before your scheduled effective date, your life insurance coverage will not become effective until the day after you complete one full day of Active Work as an eligible Member. See the Active at Work Provisions in the Certificate of Coverage.

Wavier of Premium
If you are not yet 60 years of age and become totally disabled, your life insurance may be continued without payment of premiums after completion of a 180 consecutive day waiting period. If you are

receiving disability benefits from Standard Insurance Company under the State's Short Term Disability or Long Term Disability plans, the waiver of premium benefit will be applied automatically. If you are not receiving disability benefits under the State plan, you must submit an application for waiver of premium benefits. Proof of total disability will be required. See the Waiver of Premium Provisions in the Group Term Life / AD&D Certificate of Coverage for a complete description of the benefit.

Portability of Benefits

Upon termination of employment, you may be eligible to purchase portable group insurance coverage for yourself and your insured dependents without evidence of insurability. To be eligible, you must have been continuously covered the plan (or prior plan) for at least 12 consecutive months, must be able to work, and under the age of 65. An application for portability benefits must be submitted to Standard Insurance Company with the first premium payment within 31 days after termination of employment. Coverage is provided under a separate policy issue to the Standard Insurance Company Group Insurance Trust and will contain provisions that differ from the State's Group Term Life Policy. Contact Standard Life Insurance Company for the rates. See the Portability of Insurance Provisions in the Certificate of Coverage.

Accelerated Benefit

If you are terminally ill and eligible for Wavier of Premium, you may be eligible to receive up to 75% a portion of the insurance while still living. Medical proof of terminal condition is required. See the Accelerated qualifies for Waiver of Premium Benefit Provisions in the Certificate of Coverage for details.

Right to Convert

You may be eligible to purchase an individual policy of life insurance without Evidence Of Insurability if your coverage ends or is reduced for any reason other than a) failure to pay the premium when due, or b) payment of an accelerated benefit. Contact Standard Life Insurance Company for the rates. Application must be made within 31 days after the loss of coverage. See the Right to Convert Provisions in the Certificate of Coverage for options and limitations.

How to Change your Beneficiary

You may change your beneficiary designation at any time by completing a new enrollment/change form. Submit the signed and dated form to your agency payroll or personnel administrator. All enrollment forms are maintained at your agency payroll or personnel administrator's office.

Cancelling Coverage

You may cancel your Optional Life coverage at any time by submitting an enrollment/change form to your payroll or personnel administrator. Your coverage will terminate the last day of the month of termination. You must cancel Spouse Optional Life coverage within 31 of a final divorce decree. Coverage for dependent children must be cancelled within 31 days of the date your last child becomes ineligible.

Disability coverage helps protect a portion of your income if you are disabled due to a covered illness, pregnancy, or injury. The State of Colorado offers state-paid short-term disability (STD) coverage for up to 180 days of a covered disability. Employees can also purchase long-term disability (LTD). Premiums for LTD are based on employee salary, age, and vesting status.

State of Colorado employees who have at least five years of PERA covered employment are covered by a two-tier Disability Program consisting of short-term disability (STD) insurance and a disability retirement benefit. The Employee Benefits unit provides a comparison chart of the State and PERA programs to help employees find the coverage appropriate for their needs.

Optional Long-term Disability Rates

Your monthly premium is determined by the calculation below, using your age, your base monthly salary, and whether or not you are vested in PERA.

$ _____	X _____	= $ _____
Base Monthly Salary	Factor (age group/vested or non-vested)	Monthly Employee Cost

Example: The amount for a non-vested employee, age 37, with base salary of $3000/month would be $21.60 a month. ($3000 X .0072 = $21.60)

Employee Age as of January 1, 2004	PERA Vested	PERA Non-vested
Under 30	0.0017	0.0048
30-34	0.0020	0.0059
35-39	0.0025	0.0072
40-44	0.0033	0.0102
45-49	0.0051	0.0154
50-54	0.0076	0.0229
55-59	0.0106	0.0338
60-64	0.0115	0.0346
65+	0.0140	0.0420

	State of Colorado		PERA	
	STD	**LTD**	**STD**	**Disability Retirement**
Who is eligible?	State employees based on CRS 24-50-603(7). To purchase LTD coverage, an employee must work at least 30 hours a week.		Employees who have earned five years of PERA service credit (state troopers, CBI agents and judges are eligible immediately).	
Does the employer pay for the program?	Yes	No, optional coverage available to employees for a premium, based on age, salary & vested status.	Yes, pre-funded through monthly employer contributions to PERA.	
When does coverage begin?	From the first day of active employment.	After approval from Standard Ins. Co. & first payroll deduction is taken.	Once an employee becomes vested with PERA.	
How do I apply for disability benefits?	Apply through agency payroll or personnel administrator within 30 days of absence. (P5-23A)	STD claim serves as LTD application.	Contact **PERA's Customer Service Center** to request a Disability Program brochure (includes an application and summary plan description).	
What is the benefit waiting period?	30 calendar days or state requirement for exhaustion of sick leave, whichever is later.	180 calendar days from date of disability or exhaustion of sick leave, whichever is later.	60 calendar days or state requirement for exhaustion of sick leave, whichever is later.	None.
What is the maximum benefit period?	150 days in a consecutive 12-month period = 180 days minus the 30 calendar day waiting period.	If enrolled, covered up to age 65.	Up to the first 22 months after the payment waiting period.	Lifetime, if disability continues.
How is the disability benefit calculated?	60% of pre-disability earnings based on gross weekly earnings, less deductible income, prior to disability.		60% of pre-disability PERA-includable salary (gross pay minus IRC Sec. 125 deductions) less deductible income.	Usually, 50% of **HAS**; however, it may be more or less depending upon age and service credit.
What are the maximum/minimum payments?	Max: $2,310/wk less deductible income. Min: none	Max: $10,000/month less deductible income. Min: $100.	Calculated benefits may be reduced by certain deductible income.	None.

All state employees automatically participate in the Public Employees Retirement Association (PERA). State employees have several additional easy ways to supplement their PERA retirement. You can choose the state's 457 Deferred Compensation Plan, PERA's 401k program, or one of the 403(b) tax-deferred annuity plans if you are employed by higher education. Elected and appointed officials have an option to choose between the state's 401(a) Defined Contribution Pension Plan and PERA.

For those employees who choose to contribute to one or more of the voluntary defined contribution plans listed above there is currently an employer match available. Talk to your payroll/personnel administrator for further details.

	457	*401(a) Match*	*401k*	*403(b)*
Minimum contribution	$25 per month	Varies depending on your 457 contribution	None	Contact plan `
Maximum contribution	$13,000 in 2004 $14,000 in 2005 $15,000 in 2006 Then indexed in $500 increments.	Up to 1% of PERA includable salary (2004), subject to legislation.	$13,000 in 2004 $14,000 in 2005 $15,000 in 2006 Then indexed in $500 increments.	$13,000 in 2004 $14,000 in 2005 $15,000 in 2006 Then indexed in $500 increments.
Catch-up provision	For the 3 consecutive years prior to retirement you can contribute up to twice the available limit.	Not available	Not available	With 15 years of service you may contribute up to $13,500 for 3 consecutive years.
Catch-up for participants age 50 & over (This is a combined limit between the 457, 401(k) and 403(b).)	Participants age 50 and over may make additional contributions of $3,000 in 2004 increased by $1,000 each year to $5,000 in 2006, then indexed in $500 increments. **(1)**	Not available	Participants age 50 and over may make additional contributions of $3,000 in 2004 increased by $1,000 each year to $5,000 in 2006, then indexed in $500 increments. **(1)**	Participants age 50 and over may make additional contributions of $3,000 in 2004 increased by $1,000 each year to $5,000 in 2006, then indexed in $500 increments. **(1)**
Loans	Available January 2004 for any reason.	Not available	Up to two loans at any time for any reason.	May be possible; contact plan administrator.
Distributions	Separation from service, retirement, disability, deminimus.	Retirement, disability, separation from service. **(2)**	Age 59 1/2, retirement, disability, separation from service. **(2)**	Age 59 1/2, retirement, disability, separation from service. **(2)**
Active Service Withdrawal	Unforeseeable emergency.	Unforeseeable emergency.	Financial hardship or after age 59 1/2	Financial hardship or after age 59 1/2
Purchase service credit	Yes	Yes	Yes	Yes
Rollover Provisions	Rollovers between 457, 401(k), 403(b), IRA. **(3)**	Rollovers between 457, 401(k), 403(b), IRA. **(3)**	Rollovers between 457, 401(k), 403(b), IRA. **(3)**	Rollovers between 457, 401(k), 403(b), IRA. **(3)**
Penalty on early withdrawals before age 59 1/2	No	Yes, unless rolled over to another tax-deferred account, life time monthly payments, or an exception applies.	Yes, unless rolled over to another tax-deferred account, life time monthly payments, or an exception applies.	Yes, unless rolled over to another tax-deferred account, life time monthly payments, or an exception applies.
Plan fees	Fund operating expenses; $9 annual fee assessed quarterly ($2.25); no fee for participants until July 2004.	Fund operating expenses.	Investment management fees; $18 annual fee assessed monthly ($1.50); new participants pay $12 annual fee assessed monthly ($1.00).	Contact plan administrator.
Commission, or load fees.	None	None	None	Contact plan administrator.

(1) This is a combined limit between 457, 401(k) and 403(b) plans. Over-age 50 catch-up cannot to be used at the same time as the traditional catch-up.

(2) All withdrawals are subject to ordinary income tax. A 10% federal tax penalty may apply to withdrawals made prior to age 59 1/2.

(3) Any monies rolled over from a 457 to any other plan may be subject to the 10% federal tax penalty for withdrawals made prior to age 59 1/2.

Open Enrollment for those who have continued their coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) will be from November 1, 2003 to November 30, 2003. This is a positive enrollment, meaning that you MUST enroll to continue your health and/or dental benefits in 2004. Please remember that Rocky Mountain HMO will NOT be offered in the State plans for 2004.

COBRA gives State of Colorado employees and their covered dependents the right to continue group health coverages under certain circumstances. COBRA coverage is available for medical, dental, and Healthcare FSAs. You must complete one full day of active work and have your group health coverage in effect before you are eligible for COBRA. The Information Guide explains you and your covered dependents rights under COBRA.

2004 COBRA MONTHLY RATES

The chart below reflects the 2004 COBRA Monthly Rates for the medical and dental plans listed.

Medical Plans		**Empl. Only**	**Empl + One**	**Empl. + 2/More**
Anthem Liberty EPO	Contract Rate	$324.48	$648.94	$908.50
	2% Admin Fee	$6.49	$12.98	$18.17
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	$334.27	$665.22	$929.97
Anthem Centennial PPO	Contract Rate	$220.50	$441.02	$617.46
	2% Admin Fee	$4.41	$8.82	$12.35
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	$228.21	$453.14	$633.11
Kaiser HMO	Contract Rate	$246.40	$492.78	$689.90
	2% Admin Fee	$4.93	$9.86	$13.80
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	$254.63	$505.94	$707.00
PacifiCare HMO	Contract Rate	$393.70	$787.42	$1,102.40
	2% Admin Fee	$7.87	$15.75	$22.05
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	$404.87	$806.47	$1,127.75
San Luis Valley HMO	Contract Rate	$272.76	$545.50	$764.02
	2% Admin Fee	$5.46	$10.91	$15.28
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	$281.52	$559.71	$782.60
Delta Dental Plans		**Empl. Only**	**Empl + One**	**Empl. + 2/More**
BASIC Plan - A	Premium	$16.26	$36.92	$58.00
	2% Admin Fee	$0.33	$0.74	$1.16
	Total	$16.59	$37.66	$59.16
BASIC PLUS Plan - B	Premium	$24.34	$53.90	$100.48
	2% Admin Fee	$0.49	$1.08	$2.01
	Total	$24.83	$54.98	$102.49

2004 COBRA DISABILITY EXTENSION RATES

Months 19 - 29

The chart below reflects the 2004 COBRA Disability Monthly Rates for the medical and dental plans listed.

Medical Plans		Empl. Only	Empl + One	Empl. + 2/More
Anthem Liberty EPO	Contract Rate	$324.48	$648.94	$908.50
	50% Admin Fee	$162.24	$324.47	$454.25
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	$490.02	$976.71	$1,366.05
Anthem Centennial PPO	Contract Rate	$220.50	$441.02	$617.46
	50% Admin Fee	$110.25	$220.51	$308.73
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	$334.05	$664.83	$929.49
Kaiser HMO	Contract Rate	$246.40	$492.78	$689.90
	50% Admin Fee	$123.20	$246.39	$344.95
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	$372.90	$742.47	$1,038.15
PacifiCare HMO	Contract Rate	$393.70	$787.42	$1,102.40
	50% Admin Fee	$196.85	$393.71	$551.20
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	$593.85	$1,184.43	$1,656.90
San Luis Valley HMO	Contract Rate	$272.76	$545.50	$764.02
	50% Admin Fee	$136.38	$272.75	$382.01
	Benefits Admin. Fee	$3.30	$3.30	$3.30
	Total	$412.44	$821.55	$1,149.33
Delta Dental Plans		**Empl. Only**	**Empl + One**	**Empl. + 2/More**
BASIC Plan - A	Premium	$16.26	$36.92	$58.00
	50% Admin Fee	$8.13	$18.46	$29.00
	Total	$24.39	$55.38	$87.00
BASIC PLUS Plan - B	Premium	$24.34	$53.90	$100.48
	50% Admin Fee	$12.17	$26.95	$50.24
	Total	$36.51	$80.85	$150.72

Eligibility

State employees and their eligible dependents may receive group benefits as prescribed in the Colorado Revised Statutes and the State Benefits Plans section of the State Personnel Director's Administrative Procedures. "Employee" does not include persons employed on a temporary basis. Individuals not meeting these requirements are not eligible to enroll in or be enrolled in any state group benefit plan. "Dependent" means an employee's legal spouse; each unmarried child, including natural children, adopted children, stepchildren, and foster children. Children are eligible through the end of the calendar year in which the child turns 19 years of age, for whom the employee is the major source of financial support or for whom the employee is directed by court order to provide coverage; each unmarried child 19 years of age through the end of the calendar year in which that child is no longer a full-time student in an educational or vocational institution, but no longer through the end of the month in which the full-time student turns 24 years of age, and for whom the employee is the major source of financial support or for whom the employee is directed by court order to provide coverage; or an unmarried child of any age who has either a physical or mental disability, as defined by the carrier, not covered under other government programs, and for whom the employee is a major source of financial support or for whom the employee is directed by court order to provide coverage.

Enrollment

To be covered under any state group benefit plan, employees must enroll within 31 days of their hire date or during the annual open enrollment period. To be covered under a state group medical, dental, and optional life insurance plan, eligible dependents must be enrolled within the same time frames that employees may enroll or within 31 days of an "eligible event."

The "eligible events" for enrolling dependents are:

- Marriage
- Birth
- Child placed for adoption
- Child returning to full-time student status
- Court decree requiring dependent coverage as specified in Title 14
- Placement of foster child
- Legal custody/guardianship of a child
- Child loses eligibility for Medicaid coverage
- Birth of a grandchild when parent is still an eligible covered dependent
- Unmarried child of any age who is medically certified as disabled by the carrier and dependent upon the employee as the major source of financial support no matter when the disability occurred.

Dependents are not eligible for enrollment in Basic Life/AD&D Insurance, Flexible Spending Accounts, Long-Term Disability, or Tax Deferred Savings Plans.

When choosing the most appropriate healthcare plan, it is important to understand the common terms and phrases used by health care professionals and insurance companies.

Admitting Privileges: The right granted to a doctor to admit patients to a particular hospital.

Benefit: Amount payable by an insurance company or benefit plan to a claimant, assignee, or beneficiary when an insured suffers a loss.

Case Management: A utilization management technique used to follow a patient's treatment for a specific condition that helps coordinate a number of health care services and helps ensure that individuals receive appropriate, reasonable services.

Claim: A plan participant's request to a benefit plan or insurer for the payment of certain benefits.

Co-Insurance: Co-insurance refers to percentage that an individual is required to pay for services, after a deductible is met. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.

Co-Payment: Co-payment is a predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers. For example, some HMOs require a $25 "co-payment" for each office visit. Co-payments are not specified by percentages.

Cooridination of Benefits (COB): The Primary Plan that pays first pays without regard to the possibillity that another plan may cover some expenses. The Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group plans do not exceed one hundred percent (100%) of the total allowable expense.

Dental is similar although the state plan is secondary if the employee has another Dental plan

Deductible: The amount an individual must pay for health care expenses before insurance (or a self-insured administrator) covers costs. Many health plans are based on yearly deductible amounts.

Denial Of Claim: An insurance company or plan administrator finds that a request by an individual (or his or her provider) to pay for health care services is not covered and will not be paid.

Dependent: Generally the spouse or child of a covered individual. Can be any person who relies on, or obtains coverage through, a covered individual.

Employee Assistance Programs (EAP): An employment-based health service program designed to provide early intervention and resolution of employee work-related or life problems (e.g. alcoholism, domestic violence, drug abuse, etc.) that affect job performance.

Exclusions: Prescriptions, procedures or other services that are not covered by an individual's insurance policy.

Formulary: A listing of prescription medications that are covered by a health plan. A formulary often fosters the substitution of generic or therapeutic equivalent medications for more cost-effective treatment.

Health Care Decision Counseling: Services, sometimes provided by insurance companies or employers, that help individuals weigh the benefits, risks and costs of medical tests and treatments. The goal of health care decision counseling is to help individuals make more informed choices about their health and medical care needs, and to help them make decisions that are right for the individual's unique set of circumstances.

Health Maintenance Organization (HMO): A prepaid medical group practice plan that provides a comprehensive predetermined medical care benefit package. HMOs are both insurers and providers of health care.

Indemnity Health Plan: Indemnity health insurance plans are also called "fee-for-service." plans. These are the types of plans that primarily existed before the rise of HMOs and PPOs. With indemnity plans, the individual pays a portion of the monthly insurance premiums, and an annual deductible and/or co-payments per medical visit, but the patient chooses whichever doctor or hospital he or she wants to use.

Limitations: Conditions or circumstances for which benefits are payable or limited, as detailed in an insurance policy.

Long-Term Care Policy: Insurance policies that cover specified services for a specified period of time. Long-term care policies (and their prices) vary significantly. Covered services often include nursing care, home health care services, and custodial care.

Length of Stay (LOS): A term used by insurance companies, case managers and/or employers to describe the amount of time an individual stays in a hospital or in-patient facility.

Managed Care: Health care programs that impose some controls on the utilization of health care services, providers or the fees charged for such services. Managed care can be provided through HMOs, PPOs and managed indemnity plans. The primary goal is to deliver cost-effective health care without sacrificing quality or access.

Maximum Out-of-Pocket Payment: The maximum amount of money a person will pay in addition to premium payments. An out-of-pocket payment is usually the sum of deductible and co-insurance payments.

Maximum Plan Limit: The maximum amount payable under a health plan usually separated as three limits - defined, per cause and all-causes maximum. Defined is the maximum amount the plan will pay for covered medical expenses. Per cause is the maximum limit for each separate injury or illness. All causes maximum applies to all covered expenses incurred during a specified period of time.

Open-ended HMOs: Also known as Point-of-Service (POS) plans, an HMO that provides benefits for medical care obtained from providers outside the HMO's contracted network.

Out-of-Plan: This phrase usually refers to physicians, hospitals or other health care providers who are considered non-network or outside the contracted network of an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company.

Outpatient: A person who visits a clinic, emergency room or health facility and receives health care without being admitted as an overnight patient.

Pre-Admission Certification: Also called pre-certification review, or pre-admission review. The process of obtaining certification or authorization from a health plan for hospital admissions, surgery or other procedures based.

Pre-admission Testing: A plan benefit designed to help reduce the length of hospital stays by encouraging patients to get needed diagnostic services on an outpatient basis before a non-emergency hospital admission.

Pre-existing Condition: A medical condition of an insured person that existed prior to the issuance of his or her policy. Some plans may cover these conditions after a predefined waiting period, while others may permanently exclude coverage of the condition or the person.

Preferred Provider Organization (PPO): A group of hospitals and physicians that contract on a fee-for-service basis with employers, insurance companies or third party administrators to provide comprehensive medical coverage. Using in-network providers and services allows more of an individual's costs to be covered; however, an individual can go out-of-network to receive care, but usually at a higher cost.

Primary Care Provider (PCP): The health care provider in a managed care plan who is responsible for coordinating all care for an individual patient, from providing direct care services to referring the patient to specialist and hospital care. PCPs usually include Internists, Family Practitioners and OB/GYNs.

Provider: Provider is a term used for health professionals who provide health care services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other health care professionals such as hospitals, nurse practitioners, chiropractors, physical therapists, and others offering specialized health care services.

Reasonable and Customary Fees: The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the maximum amount of money they will approve for a specific test or procedure. When out-of-network fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference. Sometimes, however, if an individual questions his or her physician about the fee, the provider may reduce the charge to the amount that the insurance company has defined as reasonable and customary.

Risk: The chance of loss, the degree of probability of loss or the amount of possible loss to the insuring company or the employer under a self-funded plan. For an individual, risk represents such probabilities as the likelihood of surgical complications, medications' side effects, exposure to infection, or the chance of suffering a medical problem because of a lifestyle or other choice. For example, an individual increases his or her risk of getting cancer if he or she chooses to smoke cigarettes.

Second Opinion: It is a medical opinion provided by a second physician or medical expert to confirm or deny the opinion of a physician who provides a diagnosis or recommended course of treatment. Individuals are encouraged to obtain second opinions whenever a physician recommends surgery or

presents an individual with a serious medical diagnosis.

Second Surgical Opinion: It is an opinion provided by a second physician, when one physician recommends surgery to an individual - also a cost management strategy that encourages or requires plan participants to obtain the second opinion of another physician after a doctor has recommended a non-emergency or elective surgery be performed.

Short-Term Disability: An injury or illness that keeps a person from working for a short time. The definition of short-term disability (and the time period over which coverage extends) differs among insurance companies and employers. Short-term disability insurance coverage is designed to protect an individual's full or partial wages during a time of injury or illness (that is not work-related) that would prohibit the individual from working. Usually provides a percentage of wages for a specified period of time.

Usual, Customary and Reasonable (UCR) or Covered Expenses: An amount customarily allowed for or covered for services and supplies which are medically necessary, recommended by a doctor, or required for treatment.

Waiting Period: A period of time when you are not covered by insurance for a particular problem.

Medical Plans

Anthem Liberty EPO/Centennial PPO.....303-831-2384
1 800-843-5621
Kaiser Permanente HMO.....303-338-3800
1 800-632-9700
PacifiCare HMO.....1 800-877-9777
San Luis Valley HMO.....719-589-3696
1 800-475-8466

Dental Plans

Delta Dental.....1 800-489-7168

Flexible Spending Accounts (FSAs)

Central/ASI Customer Service.....1 800-659-3035
Automated Account Balances & Reimbursements InfoLine 125.....1 800-366-4827
www.asiflex.com

Life Insurance & Disability

Standard Insurance Co. - General Information.....303-759-8702, Ext. 60
1 800-759-8702, Ext. 60
Standard Insurance Co. - Claims..... 1 800-252-5577

Tax Deferred Savings Plans

457 Deferred Compensation Plan - Great-West/BenefitsCorp.....1 800-838-0457
www.colorado457.com
PERA & PERA 401(k) Plan.....303-832-9550
1 800-759-7372
www.copera.org
403(b) Annuity Plan.....Contact Campus Benefits Office

401(a) Defined Contribution Pension Plan for Elected & Appointed Officials
General Information - Employee Benefits.....303-866-3434
1 800-719-3434
ICMA-RC Vantage Line.....1 800-669-7400
VALIC.....1 800-448-2542

Colorado State Employee Assistance Program

CSEAP.....303-866-4314
1 800-821-8154

Employee Benefits

Department of Personnel & Administration
Division of Human Resources - Metro Denver 303-866-3434
1 800-719-3434
www.colorado.gov/dpa/dhr